Better Birth Control
framework

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TO DECIDE

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Power to Decide developed the Better Birth Control Framework Best Practices in consultation with over 50 experts in the field of reproductive health.

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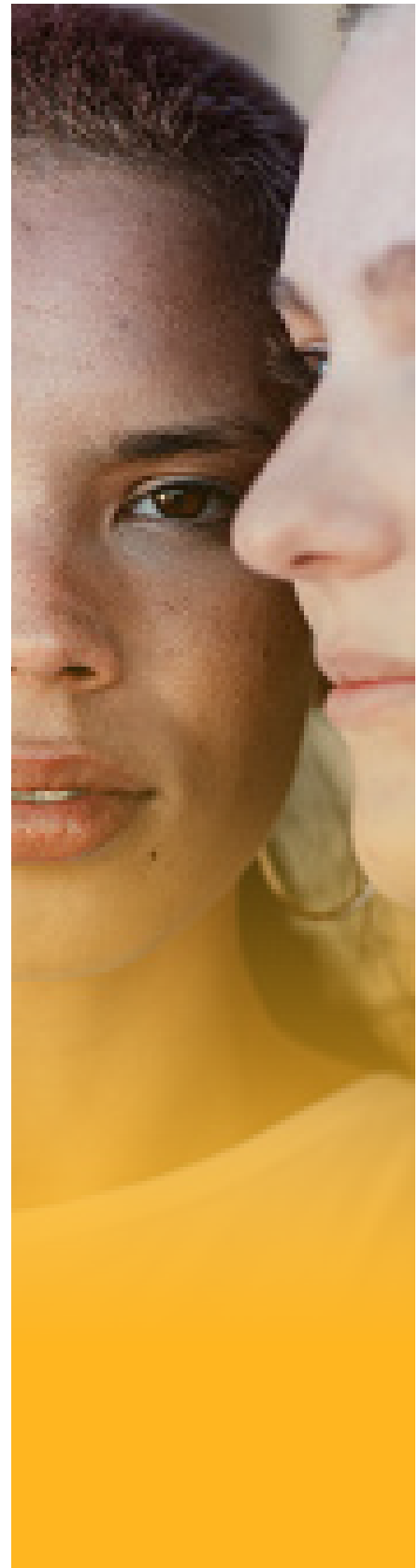
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POWER TO DECIDE

Table of Contents

POWER TO DECIDE

Introduction

Currently, only one in 50 women in need has access to the full range of birth control methods in the counties in which they live—that's more than 19 million women without reasonable access to the full range of birth control methods. These "contraceptive deserts"—places where women have unequal access to birth control based on their zip codes—can be found in states across the country. Moreover, this lack of reasonable access to all birth control methods for women contributes to the wide disparities in rates of teen and unplanned pregnancy and subsequent outcomes.

To reduce such disparities and improve equitable access to birth control, Power to Decide, the campaign to prevent unplanned pregnancy, has worked with a panel of more than 50 experts to develop a Better Birth Control (BBC) Framework of best practices that communities, states, and regions can use to guide their work to ensure that the policies, systems, programs, and financing is in place to ensure access to the full range of birth control methods for all. The BBC Framework provides a roadmap for communities. It provides specific recommendations for system-level strategies within five domains—getting started and keeping it going; health care delivery systems; policy; communications, and education; and health equity and cultural humility. When this approach is implemented within the context of a quality improvement model, it will result in strategic and sustainable change.

The Better Birth Control (BBC) Framework addresses five domains:

1. **Getting Started and Keeping it Going:** This domain includes identification of a neutral convener, establishment of key partnerships, development of community buy in and engagement, and planning for assessment, evaluation, and sustainability.

2. **Health Care Delivery System:** This domain includes clinic-level policies and practices to improve access to the full range of birth control methods. It also includes ensuring all clinic staff and providers receive training on a regular basis to improve individual skills and clinic operations in order to increase access to the full range of birth control for their clients.

3. **Policy:** This domain includes best practices on state and/or local policies (legislative, regulatory, and administrative) that address barriers to accessing the full range of contraceptive methods.

4. **Communications and Education:** This domain focuses on best practices for education, including communications and marketing, and includes broad consumer education as well as communication within a classroom or clinic location. It also focuses on both digital and interpersonal communication.

5. **Health Equity and Cultural Humility:** (interwoven within other domains): This domain focuses on ensuring the active engagement and representation of underrepresented communities and that any policies, practices, and programs addressing increased access and use of contraception are person-centered, culturally and linguistically appropriate, and inclusive.

Quality Improvement Process

We recommend using a quality improvement (QI) process to support the implementation of the BBC Framework. This is an evidence-based process that seeks to mobilize the community and is based on elements of collective impact will help build support and capacity to create long-lasting programs, policies, and practices. This process, which includes six steps outlined below, can build from existing work in the community and strives to improve collaboration for greater impact.
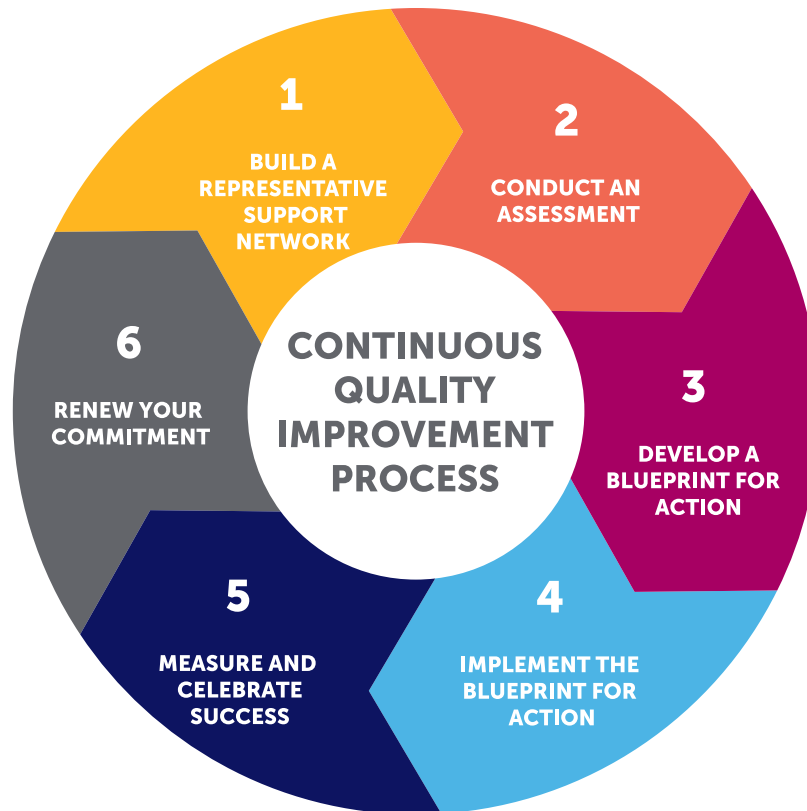
1. **Build a Representative Support Network**

   Assembling a committee of eight (minimum) to 40 people (maximum), representative of your community demographics and culture, is a key first step in the BBC initiative. This committee will work together to guide the BBC initiative, build community support, conduct an assessment, develop an action plan, identify key measure to track progress, and share success. More guidance on building this committee can be found here (BP #2, Getting Started and Keeping it Going)

2. **Conduct an Assessment**

   A needs assessment will take inventory of the current policies, programs, and practices that increase access to the full range of contraceptive methods in your community. The assessment will help the committee identify where there are strengths and where there are opportunities for improvement. More guidance on the assessment can be found here. (BP #3, Getting Started and Keeping it Going)

3. **Develop a Blueprint for Action**

   Using the results from the assessment, the committee will prioritize best practices it wishes to address, including a mix of those that are fast and relatively easy to implement as well as those that may take more time and energy. The committee will identify approximately 3-4 best practices from each of the domains to add to their annual action plan, the Blueprint for Action. More guidance on the Blueprint for Action can be found here (BP#4, Getting Started and Keeping it Going)

4. **Implement the Blueprint for Action**

   Once a best practice has been added to the Blueprint for Action, the next step is to identify resources, partners, and actions need to your committee achieve it. Each best practice has supporting guidance and resources to help communities take next steps to develop a strategic approach to achieving it. The committee is also responsible for ensuring the Blueprint for Action is implemented effectively and regularly updated. Implementation includes determining the specific tasks needed to meet each best practice, who is responsible for each task, and a timeline for completion. The committee should meet periodically to check on progress.

5. **Measure and Celebrate Success**

   The committee should update the online tool when a best practice has been achieved to track progress made on the initiative's goals. It is also important to reflect on lessons learned, so that changes for future implementation can be identified and continue to make progress. And if your committee achieved its goals in the Blueprint for Action, that should be celebrated! More guidance on measures and sharing success can be found here (BP#5 and #7, Getting Started and Keeping it Going)

6. **Renew Your Commitment**

   Sustainable systems change takes time. Your committee drives this process in your community and needs to harness the positive momentum to advance its efforts even further year after year. Thus, we encourage the committee to renew their commitment to this initiative by completing steps 1-5 every year.

   In addition to a focus on collaboration and community engagement, this process is also scalable. Replication of the same best practice framework and process in states and regions across the country will provide an opportunity to share lessons learned, challenges, and expertise efficiently and in a timely manner. This type of framework and quality improvement-based solution also ensures that states and regions interested in this work can more efficiently get started on this work in a collaborative way. Refer to "Appendix A:" for resources and guidance for implementing the best practices.

   In order to achieve full implementation of the BBC Framework, Power to Decide will work in partnership with states and regions to move through the QI process and implement the Blueprint for Action—an annual action plan developed based on the assessment and community prioritization.

Getting Started and Keeping it Going

Gaining community and leadership support is critical for any initiative seeking to change population-based outcomes. It is also critical to have a key individual or organization focused on leading these efforts to maintain forward momentum and progress. The following best practices focus on building this support and on thinking about sustainability from the beginning of the initiative in order to institutionalize change.

1. There is a neutral convener in the state/region that is qualified and committed to leading and facilitating the BBC initiative.

2. There is a state/regional committee in place that is representative of the community demographics and culture that meets at least four times per year to discuss activities and progress (Step 1 in QI process).

3. The state/region completes an annual assessment as a means of tracking progress and renewing its Blueprint for Action (Step 2 in the QI process).

4. There is a BBC Blueprint for Action that contains measurable goals and outcomes, which is updated and shared with the community (including consumers) annually.

5. Key BBC outcomes identified in the Blueprint for Action are:

   • collected and disaggregated by race, ethnicity, and socioeconomic status;

   • tracked annually (existing data sources should be used first); and

   • shared publicly at least bi-annually.

6. Existing and potential funders have been identified and are engaged.

7. There is a clear plan for collecting and reporting on consumer feedback—including youth and young adults—on the BBC initiative.

Health Care Delivery System

Supportive health care delivery system policies and practices are critical for ensuring that the full range of contraceptive methods is available when needed. The best practices focus on reducing barriers to accessing methods and on improving clinical practice so that women are satisfied with the care they receive and feel comfortable with the contraceptive method they have selected.

For the purposes of this domain, we recommend concentrating on publicly funded clinics—sites that offer "contraceptive services to the general public and use public funds to provide free or reduced-fee services to at least some clients."[1] Examples of publicly funded clinics include public health departments, Planned Parenthood Health Centers, hospitals, federally qualified health centers (FQHCs), and other independent organizations.

A majority[2] of public clinics...

1. Collect and report key measures related to provision of contraception.

    •   Key measures examine access to and experience of care associated with best practices.

    •   Use data for ongoing quality improvement.

2. Use the CDC/OPA Quality Family Planning (QFP) recommendations[3] to develop policies and practices.

3. Create an inclusive environment and ensure that services are inclusive of, appropriate for, and responsive to the needs of racial and ethnic minorities, teens, men, LGBTQIA persons, and persons with disabilities.

4. Provide confidential care to all clients.

5. Provide person-centered and autonomous care to all clients.

6. Assess pregnancy intention, along with contraceptive use, at every visit as a vital sign.

7. Offer high-quality contraception counseling using an evidence-based or -informed framework to all patients interested in avoiding pregnancy right now.

8. Offer onsite same-day access to at least one form of every FDA-approved category of contraceptive method (e.g., at least one type of IUD).

9. Offer high quality and immediate referrals to other facilities for contraceptive services if a particular method or procedure cannot be done onsite.

10. Leverage all available financial supports for family-planning services (e.g., waivers, 340B pricing, maximize third party payers, including Medicaid and MCOs, and foundation funding).

11. Have robust referral networks and/or onsite teams available to address other medical issues, as well as social issues, that can impact health.

12. Use a team-based health care delivery approach.

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1   Guttmacher Institute. Contraceptive Needs and Services, 2014 Update. Retrieved from: https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update
2   50% or more of publicly funded priority clinics (as identified by the BBC Initiative)
3   The CDC/OPA Quality Family Planning recommendations are evidence-based recommendations on how to provide direct care to clients for contraceptive services.

13. Use electronic health records (EHR) to support provision and communication of family-planning services through portals, triggers, templates, etc.

14. Follow National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.[4]

15. Use best practices for health literacy including transcreation of materials for different cultures.

16. Ensure hiring practices, job descriptions, and staff performance reviews incorporate job responsibilities related to contraceptive services and that all staff understand their role in supporting access to contraception.

Provider and Staff Training[5]

A majority[6] of public clinics...

17. Conduct annual assessments for all providers and staff.

    • Assessments are based on CDC/OPA Quality Family Planning (QFP) Recommendations.

    • Assessments include knowledge, attitude, and skill questions as they relate to the QFP.

18. Provide ongoing, comprehensive training and professional development for all providers and staff related to the provision of contraceptive services.

19. Offer training topics annually for all providers and staff not previously trained in topics critical to effective delivery of high quality contraceptive care or as new guidelines are released. Topics should include, at a minimum, the following:

    • Cultural humility and health equity;

    • Patient-centered, autonomous, and confidential care;

        • Relevant laws, regulations, and patient rights.

    • High-quality, evidence-based patient-centered contraceptive counseling;

        • Reproductive coercion (from partner or family) paired with intimate partner violence screening.

    • Pregnancy-intention screening;

    • High-quality referrals for services not provided;

    • Teen-friendly clinical practices;

    • National Standards for CLAS in Health and Health Care;

    • LARC insertion/removal and troubleshooting for complicated cases; and/or

    • Billing and coding procedures to maximize patient confidentiality and contraceptive access (including billing and coding procedures for postpartum contraception access if relevant).

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4   Fifteen standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

5   Providers and staff vary depending on the setting and may include clinicians, pharmacists, and non-licensed staff such as receptionists, medical assistants, health educators, billing staff, and others.

6   50% or more of publicly funded priority clinics (as identified by the BBC Initiative).

20. Offer additional training or resources on other important topics including:

- Working with diverse communities within their region and understanding their specific community dynamics;

- Importance of contraceptive initiative/contraception access;

- Adolescent development (including cognitive/neurological development);

- Behavior-change theory;

- Trauma-informed care; and/or

- Communication skills, specifically how to communicate with patients.

21. Have a clear plan for mentoring/proctoring and skills practice for IUD/implant insertion and removal.

22. Extend liability coverage for providers to training for LARC, including when providers go offsite for training.

Policy

State and regional policies have an impact on the ability of young adults to access the full range of methods. Policy is broadly defined for the purposes of this domain, and relates to both legislative as well as regulatory and administrative action that can reduce barriers to reasonable access. While this framework focuses on state and regional policies, many of these policies occur in the context of key federal policies and funding, which are evolving rapidly.

The policies listed below have been grouped into categories. Within each category, the policies are listed in a general order of potential impact to help guide the prioritization process.

Education

1. State and/or local policies require science-based, medically-accurate, and age-appropriate sexual health education, including information on the full range of contraceptive methods, be provided in appropriate settings (e.g., colleges, schools, child welfare programs, etc.).

Access to Providers

2. Public and private payers guarantee strong access to OB/GYN providers and other providers with specialized training in contraceptive counseling and who offer the full range of contraceptive methods onsite.

Access to Contraception Regardless of Location, Provider, or Type of Method

3. Public and private payers cover an extended supply (12 months) of self-administered hormonal contraception (i.e. birth control pills, rings, or patches) at one time, when prescribed and/or dispensed by a provider.

4. Policies allow for the provision of contraception by any willing and qualified provider including pharmacists.

5. If gaps are created by individual providers and facilities who object to birth control, they are addressed by requiring all providers (including pharmacists) and health care facilities to provide same-day referrals in the case of refusal.

6. Policies related to school- and college-based health centers allow for the provision of all methods of contraception onsite.

7. All emergency rooms are required to dispense emergency contraception (EC) to sexual assault survivors.

8. Contraception access and reimbursement is not restricted in state laws and regulations regarding telemedicine.

Medicaid/Public Insurance Coverage Programs

9. Medicaid is expanded as the ACA allows and states continue or adopt Medicaid Family Planning (FP) waivers or State Plan Amendment (SPA).

10. All of the state's Medicaid eligibility pathways (programs) are aligned to cover at least one birth control method in each of the 20 categories (18 for women and two for men) identified in the FDA Birth Control Guide.

11. Individual application and eligibility determination for "full-scope" Medicaid also includes application and eligibility determination for Medicaid family planning expansion (i.e. FP waiver or SPA); in case individuals are not eligible for full-scope Medicaid.

12. State has received approval, through an SPA, to implement Medicaid/Children's Health Insurance Program (CHIP) coverage of lawfully residing immigrant children and pregnant women without a five-year waiting period.

13. States set aside funds to cover populations excluded from federal health insurance programs.

14. There is suspension rather than disenrollment of Medicaid benefits for individuals who become involved in the justice system.

Reimbursement/Payment

Reimbursement policies can reduce barriers to consumers accessing the full range of contraception. This includes policies specific to methods and providers:

Reimbursement policies specific to methods

15. Reimbursement methods account for the full value of all contraceptive methods (including the cost of the contraceptive, relevant dispensing, and/or insertion costs) while respecting patient autonomy.

16. Covering costs of insertion and removal of IUDs and implants regardless of reason for procedure. This includes costs associated with removal when a patient loses coverage.

17. Payer sources do not prohibit same-day access to all contraceptive methods.

18. Payer sources do not impede access to immediate postpartum or immediate post-abortion provision of any contraceptive method.

19. Medicaid and private insurers cover FDA-approved over-the-counter (OTC) contraception and supplies without a prescription and without limiting the number of cycles allowable. This includes, but is not limited to EC, male and female condoms, the sponge, and spermicide.

20. Policies allow outpatient clinics to order LARC devices for specific patient from a specialty pharmacy, and bill the device to the patient's insurance (also known as white-bagging) and complementary buy-back programs exist for unused devices.

Reimbursement policies specific to providers

21. All public and private sources of payment should include, and fairly fund or reimburse, effective providers of contraceptive services. No provider's participation in a plan or program should be barred or limited based on reasons unrelated to its qualifications to effectively provide contraceptive services.

22. Mechanisms exist to encourage/require all public and private providers that serve women of reproductive age to include screening and counseling about pregnancy intention or reproductive life planning.

23. Contraception counseling provided by clinic staff (clinician or non-clinician) is reimbursable.

POWER TO DECIDE

24. Family-planning services can be reimbursed for any willing and qualified provider including pharmacists

Other

25. Private insurance plans include confidentiality policies for dependents/spouses.

Education and Communication

Given the low familiarity among adults—including young adults—regarding the full range of contraceptive methods, education and communication is a critical component to any initiative seeking to increase use of contraception. It is also the case that some specific methods will require a clinical visit, in which case consumers must have information about where they can access care. The following best practices focus on increasing demand for contraception.

1. There is an assessment of existing sexual health education efforts.

2. There is a mechanism/strategy for ongoing assessment of communication campaigns and social norms related to family formation, pregnancy, and contraception.

3. All youth have access to medically-accurate and age-appropriate sexual health education, including information on the full range of birth control methods.

4. All formal, in-person sexual health education is science-based, medically accurate, and culturally- and age-appropriate.

5. There are ongoing communication efforts, based on best practices, to increase awareness of the initiative and/or contraception.

6. There is a digital presence for the community BBC initiative.

Health Equity and Cultural Humility

Given the history of injustice surrounding birth control access specifically related to provision of devices and services for women of color and low-income women, it is critical that initiatives interested in increasing use of the full range of contraceptive methods consider best practices related to health equity and cultural humility. These best practices will also help ensure that access to services and information provided is culturally relevant.

1. There is a state/regional committee in place that is representative of the community demographics and culture that meets at least four times per year to discuss activities and progress (Step 1 in QI process).

2. Key BBC outcomes identified in the Blueprint for Action are:

   • collected and disaggregated by race, ethnicity, and socioeconomic status;

   • tracked annually (existing data sources should be used first); and

   • shared publicly at least bi-annually.

3. There is a clear plan for collecting and reporting on consumer feedback—including youth and young adults—on the BBC initiative.

4. The majority of public clinics create an inclusive environment and ensure that services are inclusive of, appropriate for, and responsive to the needs of racial and ethnic minorities, teens, men, LGBTQIA persons, and persons with disabilities.

5. The majority of public clinics provide person-centered and autonomous care to all clients.

6. The majority of public clinics use a team-based health care delivery approach.

7. The majority of public clinics follow National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.[7]

8. The majority of public clinics use best practices for health literacy including transcreation of materials for different cultures.

9. The majority of public clinics offer training topics annually for all providers and staff not previously trained in topics critical to effective delivery of high quality contraceptive care or as new guidelines are released. Topics should include, at a minimum, the following:

   • Cultural humility and health equity;

   • Patient-centered, autonomous, and confidential care;

   • Relevant laws, regulations, and patient rights.

   • High-quality, evidence-based patient-centered contraceptive counseling;

   • Reproductive coercion (from partner or family) paired with intimate partner violence screening.

   • Pregnancy-intention screening;

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7   **Fifteen standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.**

- High-quality referrals for services not provided;

- Teen-friendly clinical practices;

- National Standards for CLAS in Health and Health Care;

- LARC insertion/removal and troubleshooting for complicated cases; and/or

- Billing and coding procedures to maximize patient confidentiality and contraceptive access (including billing and coding procedures for postpartum contraception access if relevant).

10. The majority of public clinics offer additional training or resources on other topics including:

- Working with diverse communities within their region and understanding their specific community dynamics;

- Importance of contraceptive initiative/contraception access;

- Adolescent development (including cognitive/neurological development);

- Behavior-change theory;

- Trauma-informed care; and/or

- Communication skills, specifically how to communicate with patients.

11. State has received approval, through an SPA, to implement Medicaid/Children's Health Insurance Program (CHIP) coverage of lawfully residing immigrant children and pregnant women without a five-year waiting period.

12. There are ongoing communication efforts, based on best practices, to increase awareness of the initiative and/or contraception.

Appendix A:
Implementation Guidance
for Best Practices

This appendix is meant to support implementation of the Better Birth Control Framework. It provides additional information about each best practice, guidance on how to implement that best practice, and additional resources.

Getting Started and Keeping it Going

The goal of this domain is to build a Blueprint for Action that ensures a comprehensive policy and systems approach to better birth control access. Grassroots and leadership support are critical to any effort focused on population-level change, especially one for which there might be disparate views in the community. This domain focuses on building this Blueprint for Action and the support necessary for a successful BBC initiative. Below is additional guidance and resources for each of the best practices.

1. There is a neutral convener in the state/region that is qualified and committed to leading and facilitating the BBC initiative.

    A key to an effective initiative to increase access to the full range of contraceptive methods is the identification of a neutral convener/organization to lead the initiative. Success will require engagement of many different sectors underscoring the importance of a neutral convener who can bridge relationships and bring important voices to the table. This convener will provide valuable leadership for the initiative, support day-to-day operations and implementation of activities, and guide the committee through the quality improvement process. This will include coordinating the needs and resource assessment and guiding the development of the BBC Blueprint for Action. Over the course of this initiative, the convener—with support from the committee—will:

    - Guide vision and strategy;

    - Support aligned activities;

    - Establish shared measurement practices;

    - Build public will;

    - Advance policy; and

    - Mobilize funding.

An effective, neutral convener should have:

- Credibility, trust, and respect within the community as a whole and among organizations identified as key partners;

- The ability to act as an intermediary between key partners and external stakeholders;

- Proven leadership capabilities and the ability to raise awareness about the initiative and the issue of birth control access; and

- Dedicated time and staff (at least one staff member) to coordinate the initiative and day-to-day activities of the steering committee.

Resources

- Convener's checklist: http://collaborativeleadersnetwork.org/leaders/conveners-checklist/

- Strategies Guided by Best Practice for Community Mobilization: http://advocatesforyouth.org/storage/advfy/documents/Factsheets/strategies%20guided%20by%20best%20practice_8-11-14.pdf

- Collective Impact Forum, Tools for Backbones (sample RFP for a backbone organization)- https://collectiveimpactforum.org/resources/tools-backbones

- Job Descriptions: https://collectiveimpactforum.org/resources/job-descriptions-backbone-roles

2. There is a state/regional committee in place that is representative of the community demographics and culture that meets at least four times per year to discuss activities and progress (Step 1 in QI process).

   The committee is comprised of individuals who are interested in and passionate about improving outcomes for women, children, and families. The size of this group will vary depending on local needs, but should include a minimum of eight people and a maximum of 40 people. It is likely that the committee will be broken into a steering committee and smaller working groups. The role of the committee is to develop the Blueprint for Action and to provide overall strategic direction, guidance, oversight, and leadership in building community support and awareness of the issue and initiative. This will include leading the quality improvement process including conducting the assessment, developing an action plan, engaging the community, developing relationships and partnerships, implementing the action plan, and monitoring and sharing successes.

Who is on the committee?

To meet the needs of the community, it is important to engage those with a diversity of "lived experience" in the effort. Doing so will increase the relevance, resonance, and credibility of the initiative in the community writ large. This is especially important for BBC because of the historical trauma experienced by some communities due to the forced provision of birth control, forced sterilization, and use of minority populations as uninformed or unconsented test subjects related to birth control. Therefore, the committee should be diverse and include consumers/target audiences as well as key partners. It is particularly important to ensure that partners include representation from communities of color, low-income communities, and sexual minority communities. Listed below are examples of partners to consider.

Important

- Health care providers

- Health care systems

- Funders/Donors

- Payers (Insurers, Medicaid, Pharmacy Benefit Managers)

- Organizations focused on reproductive justice

- Research/evaluation

- Social or human service agencies

- Elected officials

- Education agency

- Media/Communications

- Policy centers/Think tanks

- Youth serving organizations

- Target audiences

Other Potential

- Faith community

- Academic medicine

- Accreditation boards

- Advocacy/civil rights/labor groups

- Military

- Employers/Chambers of commerce/Business groups

Committee members should include individuals at various levels, from decision makers to implementers, to those most directly impacted by this initiative (i.e. consumers/end-users). Members should also represent the community and, thus include diverse ages, racial/ethnic and gender identities, and other relevant characteristics.

Roles and Responsibilities

When establishing the committee, it is important to define members' roles and responsibilities and establish a formal agreement that includes expected outcomes from each organization/member. A key role of committee members is to champion the BBC initiative in their community and build support from key leaders and influencers.

The importance of formal support from key leaders and influencers cannot be emphasized enough. To make changes at the systems-level, key leaders need to be involved in the process and support the overall initiative. Without their support, barriers may be hard to overcome. Formal support can come in many different forms, which includes an official endorsement, "co-chairing" of steering committee or initiative, memorandum of agreement, letter of commitment, and/or commitment of resources (in kind or financial). This support will be important for institutionalizing change within systems in the state/region.

To gain formal support, it may be necessary to provide education and information about the importance of this work and the relationship between unplanned pregnancy and other community priorities, such as improved opportunity for young people, improved birth outcomes, etc. There are a number of existing resources available and states could also consider tailoring their own resources, with relevant data and other contextual information.

We recommend that the committee meet at least four times a year (with the potential for more meetings during Year 1). Throughout the BBC initiative, committee members will focus on:

- Completing the assessment, discussing findings, prioritizing best practices, and developing an action plan (Blueprint for Action). This will occur annually.

- Monitoring progress on the action plan.

- Reflecting on lessons learned, celebrating successes, and planning for next year.

Resources:

- Working Group Development: https://collectiveimpactforum.org/resources/how-lead-collective-impact-working-groups-comprehensive-toolkit

- Steering Committee Development: http://collectiveimpactforum.org/resources/tools-steering-committees

- May National Teen Pregnancy Prevention Month Planning Guidebook: https://www.advocatesforyouth.org/storage/advfy/documents/ntppm-planning-guidebook-web.pdf

- Strategies Guided by Best Practice for Community Mobilization: http://advocatesforyouth.org/storage/advfy/documents/Factsheets/strategies%20guided%20by%20best%20practice_8-11-14.pdf

- Toolbox Overview for Building Needle-Moving Community Collaborations: https://www.serve.gov/sites/default/files/ctools/CommunityCollaborativeToolkit_all%20_materials.pdf

- Responsibilities of Steering Committee and Working Group Members: https://collectiveimpactforum.org/resources/steering-committee-and-working-group-roles

- Building a Broad Stakeholders Group: https://collectiveimpactforum.org/resources/building-broad-stakeholders-group

- Billion Dollar Bets: https://www.bridgespan.org/insights/library/big-bets/billion-dollar-bets-reduce-unintended-pregnancies

3. The state/region completes an annual assessment as a means of tracking progress and renewing its Blueprint for Action (Step 2 in the QI Process)

The neutral convener will lead the BBC Best Practices Assessment annually to measure progress and identify next steps (Step 2 in QI process). Existing needs assessment data in the community can serve as a supplemental source for completing the BBC assessment. The neutral convener will also coordinate efforts to determine priority areas, develop the BBC Blueprint for Action, and track progress on the action plan.

As part of the annual assessment, community asset mapping should be used to identify clinics, community based-organizations, and public agencies that are related to increasing access to birth control. This process identifies strengths and resources in a community. For the purposes of the BBC Initiative, the representative committee and other initiative partners will identify people, organizations, and services that play a role in birth control access. Mapping provides an opportunity to define your community, i.e. on a map, and identify your strengths and weaknesses as well as potential partners. Key to this initiative is the mapping of clinical services in your community. This list will help you identify which clinics you will focus on for the Health Care Delivery System domain.

Resources:

- Conducting Community Needs Assessment: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conducting-needs-assessment-surveys/main

- Contraception Deserts: https://powertodecide.org/what-we-do/access/access-birth-control

- Identifying Community Assets and Resources: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

- UCLA Center for Health Policy Research, Section 1, Asset Mapping: http://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba20.pdf

- Community Science, Participatory Asset Mapping: http://www.communityscience.com/knowledge4equity/AssetMappingToolkit.pdf

4. There is a BBC Blueprint for Action that contains measurable goals and outcomes, which is updated and shared with the community (including consumers) annually.

The Blueprint for Action is the most important practice in the BBC effort, as it serves as the strategic roadmap, tactical implementation guide, and sustainability plan for the BBC initiative. To that end, it should include goals and outcomes of the initiative that are determined through the Steering Committee. This will help encourage a focus on long-term goals and outcomes along with specific action items. Including information about future funding and sustainability will also be important to consider from the beginning.

The Blueprint for Action should be developed following the completion of the BBC Assessment. The Steering Committee will identify priority action items to be added to the Blueprint for Action based on potential impact, cost, time, commitment, and feasibility of achieving the best practice. This should be updated annually (or more often as best practices are achieved) based on BBC Assessment results.

Key priority partners will be needed to implement the Blueprint for Action. Formal partnerships are memorialized in the form of a memorandum of agreement, letter of commitment, or other formal contract. Regardless of the form, partners should proactively outline their various key roles and responsibilities and set measures of success. Ideally, this formalized agreement should be between the neutral convener and each committee member organization or individual.

Progress on the Blueprint for Action should be shared with the community at least annually. This helps support community mobilization and engagement in the process. To this end, informing the community about progress, perhaps through an annual recognition or awards luncheon, reception, or dinner is an opportunity to both inform the community about the work as well as engage new voices in the initiative. Recognizing members of the Steering Committee for their efforts is also important to keep momentum high. Sharing progress on the action plan, as well as outcome data, can build stakeholder engagement, foster new partnerships, and support communication efforts to increase awareness.

Resources:

- BBC Action Plan: to be added when portal is live

- Prioritization and Action Planning Tool:

- Building Sustainable Programs—The Framework: https://www.hhs.gov/ash/oah/sites/default/files/creating_sustainableimpacts_framework.pdf

- Strategies for the Long-Term Sustainability of an Initiative: An Overview: http://ctb.ku.edu/en/table-of-contents/sustain/long-term-sustainability/overview/main

- Understanding and Writing Contracts and Memoranda of Agreement: http://ctb.ku.edu/en/table-of-contents/structure/organizational-structure/understanding-writing-contracts-memoranda-agreement/main

- Toolbox Overview for Building Needle-Moving Community Collaborations: https://www.serve.gov/sites/default/files/ctools/CommunityCollaborativeToolkit_all%20_materials.pdf

- Stakeholder Education: Strategies Guided by Best Practices: https://powertodecide.org/what-we-do/information/resource-library/stakeholder-education-strategies-guided-best-practice

5. Key BBC outcomes identified in the Blueprint for Action are:

- collected and disaggregated by race, ethnicity, and socioeconomic status;

- tracked annually (existing data sources should be used first); and

- shared publicly at least bi-annually.

Measures should include but are not limited to:

- National Quality Forum Contraceptive Provision Measures (at the clinic level).

    - The percentage of women age 15-44 at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, contraceptive implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectable, oral pills, patch, ring, or diaphragm) method of contraception.

- Rate of teen pregnancy (or births if pregnancy is not available).

- Proportion of pregnancies that are unintended (or rate if available).

- Rapid repeat births (defined as less than 18 months since last birth).

- There is at least one clinic/provider offering the full range of contraceptive methods for every 1,000 women in need of publicly funded contraceptive services.

These data should provide a good snapshot of both areas of need for focus of the initiative as well as progress throughout the initiative. Collecting the measures will depend on existing data sources within the state/region (for example, data from the health department) along with clinical data. Whenever possible, these data should be disaggregated by race, ethnicity, and socioeconomic status. Disaggregated data can help identify health disparities within your community, monitor progress, and inform program implementation. It is important to consider the context for the data and to include diverse voices when interpreting results. Ensuring diverse representation on the Steering Committee from the beginning of the initiative will help with this process and can be important for helping to understand reasons why data may suggest progress or lack of progress.

In addition, data should be collected and reported by zip code or other method to track geographic differences. In an effort to engage and inform the community, these data should also be shared with community members. Sharing can occur through the creation and dissemination of tip sheets or infographics, in-person presentations and meetings, through a website, or through some other mechanism deemed appropriate by the Steering Committee.

The Office of Population Affairs (OPA) has identified three contraceptive measures to help clinics assess the provision of contraceptives to women in need. Guidance from OPA related to the provision of long-acting reversible contraceptives (LARCs) indicates that performance measures should *not* be used to encourage high rates of use as this may lead to coercive practices. This type of measure should only be used to identify locations where barriers to the provision of IUDs or implants may exist. Additional performance measures can be found in the CDC/OPA Quality Family Planning Recommendations.

Teen pregnancy and birth rates, pregnancy intention, and rapid repeat birth data should be available through your local or state health department's epidemiology office. If you are unable to track the measures selected above, identify similar measures that can serve as outcome data.

Other data sources include:

Power to Decide:

- Data Portal: https://powertodecide.org/what-we-do/information/national-state-data/national

- Contraception Deserts: https://powertodecide.org/what-we-do/access/access-birth-control

Guttmacher Institute:

- Unintended Pregnancy Rates: https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states

- State Fact Sheets—Untended Pregnancy: https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy

CDC:

- Pregnancy Risk Assessment Monitoring System (PRAMS): https://www.cdc.gov/prams/index.htm

Other important indicators to monitor for potential impact (from data sources such as the County Health Rankings/Kids Count Data):

- Poverty

- Educational attainment

- Income

- Employment level

- Use of public benefits (WIC, Medicaid, etc.)

- Child abuse and neglect

- Infant mortality

- Preterm births

- Low birthweight

Since unplanned pregnancy also has an impact on other indicators of interest, and other challenges can impact unplanned pregnancy rates and contraceptive access and use, we recommend monitoring other relevant data. These data may be particularly relevant for determining geographic areas with greatest need or vulnerable populations. Steering Committee members may discuss the most relevant data to use based on the context of their state/region.

Data sources for these types of indicators include:

- Kids Count Data Center: http://datacenter.kidscount.org/

- County Health Rankings: http://www.countyhealthrankings.org/

- CDC/OPA Quality Family Planning Recommendations: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w

- Opportunity Index: http://opportunityindex.org/mobile/

Resources:

- OPA Performance Measures: Contraceptive Care Measures: https://www.hhs.gov/opa/performance-measures/index.html

- Safe Schools Healthy Schools, The Importance of Disaggregating Student Data: http://www.promoteprevent.org/sites/www.promoteprevent.org/files/resources/The%20importance%20of%20disaggregating_0.pdf

6. Existing and potential funders have been identified and are engaged.

    Engaging governmental and non-governmental funders will be important for leveraging resources for this work. Consider engaging key funders as thought partners from the beginning to help align the initiative with other community priorities and needs and ensure that funders have a full understanding of how this work can support their overall missions and goals.

Resources:

- Mobilizing and Managing Funding: http://sparkpolicy.com/tools/overview-2/mobilizing-managing-funding/

- The Role of Investors: Lessons Learned on Critical Roots That Drive Quality Collective Impact: https://collectiveimpactforum.org/sites/default/files/investors-role-collective-Impact-lessons-leasrned.pdf

- Toolbox Overview for Building Needle-Moving Community Collaborations: https://www.serve.gov/sites/default/files/ctools/CommunityCollaborativeToolkit_all%20_materials.pdf

7. There is a clear plan for collecting and reporting on consumer feedback—including youth and young adults— on the BBC initiative.

    Consumer feedback can be both qualitative (e.g. focus groups, in-depth interviews) and quantitative (e.g. surveys). Collecting and assessing consumer feedback should also be structured in such a way that any information on unintended consequences of the initiative is captured and reported back to the Steering Committee. Feedback should be reported back to all BBC initiative partners and the community. Examples of ways that consumer feedback is collected and reported in other initiatives includes ongoing surveys and polling data, ongoing focus groups and in-depth interviews, and ongoing assessment of satisfaction with respect to changes in services offered, etc.

    Given that unplanned pregnancy is most prevalent among young women, specifically those ages 18-24, and a primary goal of improving access to the full range of contraceptive methods is reducing unplanned pregnancy, youth and young adults should play key roles in the BBC initiative. Specific roles may include youth serving on the steering committee, acting as an advisor, or a researcher (e.g. youth-led participatory research). Youth can provide perspective, insight, and new ideas to increase the impact of the BBC Initiative.

Resources:

- Providing Integrated and Teen-Friendly Reproductive Health Services: How to Assess and Strengthen Your Service Interventions (p 61-69): https://intranet.bixbycenter.ucsf.edu/publications/files/ProvidingIntegratedServices_2010_FINAL.pdf

- Improving Contraceptive Access: Tools for Providers (specifically Patient Experience Survey); https://www.cdc.gov/teenpregnancy/health-care-providers/improving-contraceptive-access.html

- Conducting Focus Groups: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-focus-groups/main

- Conducting Interviews: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-interviews/main

- Conducting Surveys: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-surveys/main

- Strategies Guided by Best Practice for Community Mobilization: http://advocatesforyouth.org/storage/advfy/documents/Factsheets/strategies%20guided%20by%20best%20practice_8-11-14.pdf

- Including Youth on Your Board, Commission, or Committee: http://ctb.ku.edu/en/table-of-contents/structure/organizational-structure/include-youth/main

- Engaging Youth in Community Decision Making: http://www.cssp.org/community/constituents-co-invested-in-change/other-resources/engaging-youth-in-community-decision-making.pdf

- Core Principles for Engaging Young People in Community Change: http://forumfyi.org/files/FINALYouth_Engagment_8.15pdf.pdf

- What is Youth Engagement, Really?: http://www.actforyouth.net/youth_development/engagement/

Health Care Delivery System

Supportive health care delivery system policies and practices are critical for ensuring that the full range of contraceptive methods is available when needed. These best practices focus on optimizing health care delivery systems to reduce barriers to birth control methods and on improve the quality of clinical practice so that women are satisfied with the care they receive and feel comfortable with the contraceptive method they have selected.

For the purposes of this domain, we recommend concentrating on publicly-funded clinics—sites that offer "contraceptive services to the general public and use public funds to provide free or reduced-fee services to at least some clients."[8] Examples of publicly funded clinics include public health departments, Planned Parenthood Health Centers, hospital clinics, federally qualified health centers (FQHCs), Title X clinics, and other independent organizations.

A resource-mapping process is recommended to identify publicly-funded clinics. From this list, identify where the majority of your target population goes for medical care to determine an initial list of priority clinics to engage in BBC Initiative efforts. Each of the following best practices would be considered met if a majority of those priority clinics in the defined community/region are using the best practice. Clinic-level assessments must be conducted to determine if best practices are being used.

A majority[9] of public clinics...

1. Collect and report key measures related to provision of contraception.

    •   Key measures examine access to and experience of care associated with best practices.

    •   Use data for ongoing quality improvement.

Each clinic in your community should collect data about patients' access to birth control and their experience at the clinic. These data should be regularly monitored and used to improve the clinical experience for patients.

The Office of Population Affairs (OPA) developed key measures for family planning clinics to collect related to access. One example includes:

•   The percentage of women age 15-44 at risk of unintended pregnancy that are provided a most effective (i.e., sterilization, contraceptive implants, intrauterine devices or systems (IUD/IUS) or moderately effective (i.e., injectable, oral pills, patch, ring, or diaphragm) method of contraception.

Resources:

•   OPA Contraceptive Provision Measure Specifications: https://www.hhs.gov/opa/sites/default/files/contraceptive-use-specifications-global-2015.pdf

•   OPA Contraceptive Provision Performance Measures: https://www.hhs.gov/opa/performance-measures/index.html

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8   Guttmacher Institute. Contraceptive Needs and Services, 2014 Update. Retrieved from: https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update

9   50% or more of publicly funded priority clinics (as identified by the BBC Initiative)

- IHI How to Improve (Quality Improvement Process): http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

- Family Planning and Reproductive Health Indicators Database: https://www.measureevaluation.org/prh/rh_indicators

- Using the Contraceptive Provision Measures in the Title X Program: https://www.fpntc.org/search?keys=contraceptive%20care%20measures

- Interpreting Rates for Contraceptive Provision Measures: https://www.hhs.gov/opa/sites/default/files/interpreting-rates-for-contraceptive-care-measures.pdf

- Effective Contraceptive Use among Women at Risk of Unintended Pregnancy Guidance Document (Oregon Health Plan): https://www.oregon.gov/oha/analytics/CCOData/Effective%20Contraceptive%20Use%20Guidance%20Document.pdf

- Cooperative of American Physicians' Patient Experience Survey Program: https://www.capphysicians.com/patient-experience-survey-program

- Using Billing Codes to Measure Performance: http://www.contraceptiveactionplan.org/index.php/tools-and-resources-menu-item/cap-birth-control-options-grid-3

- CDC Community and Clinical Partner Clinical Partner Needs Assessment: https://www.cdc.gov/teenpregnancy/pdf/about/community-clinical-partner-clinical-partner-need-assessment-707kb.pdf

2. Use the CDC/OPA Quality Family Planning (QFP) recommendations to develop policies and practices.

   The Quality Family Planning recommendations were developed by the CDC and OPA. The CDC and OPA have a long history of developing evidence-based recommendations for clinical care and OPA has been the national leader in family planning services. The recommendations address a wide-range of services including contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services.

Resources:

- Putting the QFP into Practice Series: https://www.fpntc.org/search?keys=putting+the+QFP+into+practice&=Search

- CDC/OPA Quality Family Planning Recommendations (QFP): https://www.cdc.gov/reproductivehealth/unintendedpregnancy/qfp.htm

- Quality Family Planning Services Mobile App: http://www.ctcfp.org/qfp-app-for-desktop/

3. Create an inclusive environment and ensure that services are appropriate for and responsive to the needs of racial and ethnic minorities, teens, men, LGBTQIA persons, and persons with disabilities.

   Contraceptive services should be available in a positive, person-centered environment that respond to the needs of all patients regardless of race/ethnicity, national origin, religion, age, gender or perceived gender, sexual orientation, and abilities. The clinic's policies, staff attitudes and practices, and the physical environment can all impact the inclusiveness of the clinic. Staff training and ongoing professional development can help improve the culture and practices of the clinic.

General Resources:

- Sexual and Reproductive Health Care Best Practices for Adolescents and Adults: http://www1.nyc.gov/assets/doh/downloads/pdf/ms/srh-clinical-guide.pdf

- Sexual Health and Your Patients: A Provider's Guide: http://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/sexual-health-and-your-patients-a-providers-guide

Race and Ethnicity Resources:

- ACOG Statement of Policy on Racial Bias: https://www.acog.org/-/media/Statements-of-Policy/Public/StatementofPolicy93RacialBias2017-2.pdf?dmc=1&ts=20170719T1409058420

- Think Cultural Health: https://www.thinkculturalhealth.hhs.gov/

- Disparities in Family Planning: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/

- Health Disparities Online Workshop and Videos: http://innovating-education.org/category/abortion-access/health-disparities/

- 10 Ways to Make Your Health Center More Welcoming for Diverse Students: http://www.acha.org/documents/resources/10Ways_WelcomeDiversity.pdf

- Racism in Family Planning Care: https://providers.bedsider.org/articles/racism-in-family-planning-care

- Cross-cultural Communication with Immigrant and Refugee Patients: http://www.arhp.org/Publications-and-Resources/Clinical-Fact-Sheets/Cross-Cultural

Teen Resources:

- Contraceptive and Reproductive Health Services for Teens: Evidence-based Clinical Best Practices:

- https://www.cdc.gov/teenpregnancy/pdf/prevent-teen-pregnancy/fact-sheet-contraceptive-reproductive-health-services-teens_tagged-508.pdf

- AAFP Adolescent Confidentiality: http://www.aafp.org/about/policies/all/adolescent-confidentiality.html

- Confidential Care for Adolescents: https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Aug-04-Confidential_Health_Care_for_Adolescents.pdf

- Best Practices for Youth-Friendly Sexual and Reproductive Health Services in Schools: http://www.advocatesforyouth.org/storage/advfy/documents/bp-youth-friendly-services.pdf

- A Teen-Friendly Reproductive Health Visit: https://www.cdc.gov/teenpregnancy/health-care-providers/teen-friendly-health-visit.htm

- Sexual and Reproductive Health Care Best Practices for Adolescents and Adults: http://www1.nyc.gov/assets/doh/downloads/pdf/ms/srh-clinical-guide.pdf

- Assessment Tool for Providing Teen-Friendly Services: https://intranet.bixbycenter.ucsf.edu/publications/files/ProvidingIntegratedServices_2010_FINAL.pdf

- Youth Friendly Services Assessment Tool: http://www.healthyteennetwork.org/resources/youth-friendly-services-assessment

Men's Resources:

- Checklist for Family Planning and Related Health Services: https://www.fpntc.org/resources/family-planning-and-related-preventive-health-services-checklists-women-and-men

- Clinical Pathway for Determining FP Services for Men and Women: https://www.fpntc.org/resources/clinical-pathway-family-planning-services-chart

- Preventive Male Sexual and Reproductive Health Care: https://www.guideline.gov/summaries/summary/48456

- Caring for Men's Reproductive Health Needs: http://core.arhp.org/search/searchDetail.aspx?itemId=1335

LGBTQIA Resources:

- Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff: https://www.lgbthealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf

- Providing Affirmative Care for Patients with Non-binary Gender Identities: https://www.lgbthealtheducation.org/wp-content/uploads/2017/02/Providing-Affirmative-Care-for-People-with-Non-Binary-Gender-Identities.pdf

- 10 Things to Create Inclusive Health Care Environments: http://www.lgbthealtheducation.org/wp-content/uploads/Ten-Things-Brief-Final-WEB.pdf

- Sexual Health and Your Patients: A Provider's Guide: http://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/sexual-health-and-your-patients-a-providers-guide

- Improving Reproductive Health Care for Transgender Oregonians: http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Resources/OR-RH-trans-resource.pdf

- Avoiding Assumptions about LGBT Patients: http://core.arhp.org/search/searchDetail.aspx?itemId=1333

- Creating A Safe Space for LGBT Patients: http://core.arhp.org/search/searchDetail.aspx?itemId=1343

- Gay Men and Reproductive Health: http://core.arhp.org/search/searchDetail.aspx?itemId=1350

- Recommendations for Working With Bisexual Patients: http://core.arhp.org/search/searchDetail.aspx?itemId=1378

- Sample Intake Form Questions for LGBT Friendly Providers: http://core.arhp.org/search/searchDetail.aspx?itemId=1390

Disabilities Resources:

- Promoting Sexual and Reproductive Health for Persons with Disabilities: https://www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf

- Sexual and Reproductive Health Care Best Practices for Adolescents and Adults: http://www1.nyc.gov/assets/doh/downloads/pdf/ms/srh-clinical-guide.pdf

4. Clinics provide confidential care to all clients.

Clinics should have confidentiality policies and practices that reflect state and federal laws and should share these policies with patients prior to receiving services. While HIPAA provides protections for privacy of medical records, there are a few exceptions. Insurance companies are required to send Explanation of Benefits (EOBs) to the primary insurance holder following insurance claims or other actions occurring on their policy. This is meant to reduce insurance fraud and hold the insurance company accountable. Patients who are considered dependents on their spouse's or parents' insurance, especially young adults and adolescents, want to keep the services they receive private. Many states have developed innovative ways to ensure this privacy. The Guttmacher Institute's Protecting Confidentiality for Individuals Insured as Dependents tracks related state policies. Clinics should provide information about EOBs to patients and provide assistance to suppress EOBs or referrals to other medical providers where costs are minimal or free when not using insurance and ensure confidentiality (e.g. Title X clinics).

In addition to the EOB concern, youth under the age of 18 may not have the same protections for accessing and receiving reproductive health services. Most states have laws that explicitly allow minors to access confidential contraceptive services, but there may be specific conditions that need to be met such as age, marriage, or parenting status. Four states currently have no explicit law regarding minor consent. All clinic staff should be trained on and provide care based on these state-by-state laws. The Guttmacher Institute annually tracks state polices related to minor consent laws for reproductive health services.

Resources:

- The Guttmacher Institute Minor Consent Laws: https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law

- Protecting Confidentiality for Individuals Insured as Dependents: https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents

- Confidentiality in Health Care: Adolescent And Young Adult Clinical Care Resources: https://www.adolescenthealth.org/Resources/Clinical-Care-Resources/Confidentiality.aspx

- Healthy Teens Initiative Seven Steps to Comprehensive Sexual and Reproductive Health Care for Adolescents in New York City: https://www1.nyc.gov/assets/doh/downloads/pdf/ms/ms-hti-guide.pdf

- Minor Rights: Access and Consent to Health Care: https://public.health.oregon.gov/HealthyPeopleFamilies/Youth/Documents/minor-rights.pdf

5. Clinics provide person-centered and autonomous care to all clients.

Person-centered (i.e. patient-centered, client-centered) care is health care that is respectful and responsive to individual preferences, needs, and values. These preference, needs, and values guide clinical

decisions. Autonomous care empowers and allows patients to make their own decisions about health care, such as which birth control method to use. This also includes creating and sustaining a mechanism to ensure responsiveness to patient needs and follow-up support.

Resources:

- Client-Centered Counseling Model: http://www.contraceptiveactionplan.org/index.php/tools-and-resources-menu-item/cap-5-steps-of-contraceptive-counseling-model

- Patient- and Family-Centered Care Organizational Self-Assessment Tool: http://www.ihi.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx

- Upstream Training—Patient-Centered Counseling: http://www.upstream.org/our-training/

6. Assess pregnancy intention, along with contraceptive use, at every visit as a vital sign.

   Patients of reproductive age should be asked about pregnancy intention at every visit regardless of the reason for the appointment. This promotes the idea that outcomes are best when pregnancies are intended and planned, and provides an opportunity to discuss not only contraception, but ways to support healthy pregnancies. Depending on the patient's response, a medical provider can provide contraceptive counseling or preconception care. Two examples of tools for assessing pregnancy intention include:

   - CDC's Reproductive Life Plan Tool: https://www.cdc.gov/preconception/rlptool.html

   - One Key Question®: https://powertodecide.org/select360-consulting

Resources:

- The Importance of Preconception Care in the Continuum of Women's Health Care: https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Importance-of-Preconception-Care-in-the-Continuum-of-Womens-Health-Care?IsMobileSet=false

- CDC/OPA Quality Family Planning Recommendations: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w

7. Offer high-quality contraception counseling using an evidence-based or -informed framework to all patients interested in avoiding pregnancy right now.

   Contraceptive counseling is a practice to help clients make decisions about their contraceptive use. According to the Quality Family Planning guidelines, effective contraceptive counseling includes the following:

   - Building rapport with client,

   - Obtaining clinical and social information,

   - Working with client to select the most appropriate method,

   - Conducting a physical exam only when necessary,

   - Providing the contraceptive method,

- Instructing client on use and developing a plan for consistent use, and

- Confirming client understanding of method and how to use it.

There are a variety of contraception counseling models including:

- Shared Decision Making:

  - Shared Decision Making is a health communication model based on the patient and provider working together.

  - During Shared Decision Making, the patient and provider collaborate to make health care decisions that are consistent with the patient's preferences, but also include the provider's knowledge and expertise.

- Tiered Effectiveness

  - Tiered Effectiveness is a contraceptive counseling model based on contraceptive efficacy.

  - During Tiered Effectiveness counseling, patients are presented with contraceptive options based on each method's efficacy for pregnancy prevention—with high efficacy methods presented first, followed by lower efficacy methods.

- Task-Oriented Communication:

  - Task-oriented communication is a six-step method for contraceptive counseling. The steps include:

    ◦ Counseling women on the side effects and risks of contraception.

    ◦ Communicating about contraceptive efficacy in an understandable, relatable way.

    ◦ Anticipating and addressing barriers to contraceptive usage.

    ◦ Addressing the patient's pregnancy risk, and any misconceptions about pregnancy risk.

    ◦ Providing counseling for dual protection.

    ◦ Screening for and addressing concerns about reproductive coercion.

- Relational Communication:

  - Relational communication is a contraceptive counseling approach that emphasizes perceived satisfaction with the family planning experience.

  - Relational communication involves developing a close relationship with the client (patient), building trust, and applying the principals of informed choice and shared decision making.

  - Providers can use relational communication to improve a patient's perceived satisfaction with the family planning experience, with the goal of improving contraception usage.

- Client-Centered Counseling:

    - Client-centered counseling for contraception is based on client (patient) decision-making.

    - Client-centered counseling focuses on what the client needs to achieve their desired health outcomes and allows the client the opportunity to ask questions.

    - Methods for client-centered counseling include the OARS Method, the Teach-Back Technique, and the GATHER approach.

- Motivational Interviewing:

    - Motivational Interviewing (MI) is a patient-centered counseling style, based on establishing a relationship between the counselor and patient.

    - MI involves open-ended questions, reflective listening, empathetic statements, and exploration of desire for behavior change.

    - MI focuses on the patient's preferences for contraception, contraception decision making skills, and autonomy (rather than solely focusing on the provider's expertise).

In addition, there are technology-based decision support tools developed and used by providers to guide the contraceptive counseling process.

Resources:

- Providing Quality Contraceptive Counseling and Education: A Toolkit for Training Staff: http://www.cardeaservices.org/resourcecenter/providing-quality-contraceptive-counseling-education-a-toolkit-for-training-staff

- Quality Contraceptive Counseling and Education: A Client-Centered Conversation: https://www.fpntc.org/training-and-resources/quality-contraceptive-counseling-and-education-a-client-centered-conversation

- NYC Sexual and Reproductive Health Care Best Practices for Adolescents and Adults: http://www1.nyc.gov/assets/doh/downloads/pdf/ms/srh-clinical-guide.pdf

- The SHARE Approach: https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

- Client-Centered Counseling Models and Resources: https://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Documents/edmat/Client-CenterCounselingModelsandResources.pdf

- Contraceptive Counseling Resource Digest: https://www.acog.org/-/media/Departments/LARC/ContraceptiveCounselingReplaceable.pdf?dmc=1&ts=20170719T1421194060

- Contraceptive Counseling Training: http://larcfirst.com/counselors.html

- GATHER Guide to Counseling: https://www.k4health.org/sites/default/files/j48.pdf

- Tiered Effectiveness Tool: https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf

- Motivational Interviewing: A Tool for Behavior Change: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Motivational-Interviewing-A-Tool-for-Behavior-Change

- Improving Contraceptive Counseling through Shared Decision Making Curriculum: http://innovating-education.org/2016/03/2743/

- Decision Making Tool for Family Planning Clients and Providers: http://www.who.int/reproductivehealth/publications/family_planning/Technical_adaptation_guide.pdf

8. Offer onsite same-day access to at least one form of every FDA-approved category of contraceptive method (e.g., at least one type of IUD).

To reduce barriers to accessing contraceptive methods, clinics should ensure that methods are available on the same day and within the clinic, when medically appropriate. Offering a broad range of contraceptive methods is key to providing patient-centered care. Clients' ability to choose and obtain a method of their choice can lead to more consistent and correct use of a chosen method.

Clients may face transportation, childcare, and work-related barriers when another appointment or a referral to another clinic is made. By providing same-day and onsite access, you can greatly reduce such barriers, which may affect contraceptive use.

Resources:

- Intrauterine Devices and Implants: A Guide to Reimbursement (includes information on stocking of methods): https://www.nationalfamilyplanning.org/file/documents----reports/LARC_Report_2014_R5_forWeb.pdf

- Contraceptive Access Change Package (Best Practice 1 and 3): https://www.fpntc.org/resources/contraceptive-access-change-package

- LARC Modeling Tool (tool to build the case to support the provision of IUDs and implants): http://www.caiglobal.co/larc/

- Quick Start Algorithm for Contraception: http://www.reproductiveaccess.org/wp-content/uploads/2014/12/QuickstartAlgorithm.pdf

- Upstream Training: http://www.upstream.org/our-training/

- Payment Strategies for LARC: http://www.astho.org/MCH/LARC/White-Bagging-Factsheet/

- Beyond the Pill (training): http://beyondthepill.ucsf.edu/

9. Offer high-quality and immediate referrals to other facilities for contraceptive services if a particular method is not available onsite.

    Every clinic should have an established referral network to other contraceptive service providers to expedite and ease clients' access to contraceptive methods not available onsite. Clinics can provide a listing of available providers, assist with making the appointment, and/or alert the referral site that a referral was made (QFP).

Resources:

*   Developing a Referral System for Sexual Health Services: http://connectionsforstudentsuccess.org/index.php/referral-kit-download/referral-kit-download-2

*   Establishing Organizational Partnerships to Increase Student Access to Sexual Health Services: http://www.ncsddc.org/sites/default/files/docs/organizational_partnerships-10-17-16.pdf

*   CDC Project Connect: https://www.cdc.gov/std/projects/connect/

*   Providing Integrated And Teen Friendly Reproductive Health Services: How to Assess and Strengthen Your Service Interventions: https://intranet.bixbycenter.ucsf.edu/publications/files/ProvidingIntegratedServices_2010_FINAL.pdf

10. Leverage all available financial supports for family-planning services (e.g., waivers, 340B pricing, maximize third party payers, including Medicaid and MCOs, and foundation funding).

    Cost, both for the patient and provider/clinic, is often one barrier cited for not providing the full range of birth control methods. IUDs and implants are more expensive, harder to stock, and payments and reimbursements may not cover the full cost of the device and procedures. As clinics move towards providing the full range of methods, there are a variety of financial supports that can be leveraged to reduce these barriers.

    The 340B Drug Pricing Program allows eligible clinics (safety-net clinics including Title X) and hospitals to purchase outpatient prescription drugs, over-the-counter drugs (accompanied by a prescription), and clinic-administered drugs at a lower cost (between 25-50% of regular retail).

    Coverage through public or third-party payers should be determined and used prior to foundation funding.

Resources:

*   Intrauterine Devices & Implants: A Guide to Reimbursement: http://larcprogram.ucsf.edu/

*   Overview of 340B Drug Pricing Program: http://www.340bhealth.org/340b-resources/340b-program/overview/

*   Contraceptive Access Change Package (Best Practice 4): https://www.fpntc.org/resources/contraceptive-access-change-package

*   Financial Sustainability Calculator for Safety-Net Family Planning Centers: https://www.guttmacher.org/report/safety-net-centers-sustainability-calculator

- Financial Management Resources: https://www.fpntc.org/training-packages/financial-management

- Intrauterine Devices and Implants: A Guide to Reimbursement: https://www.nationalfamilyplanning.org/file/documents----reports/LARC_Report_2014_R5_forWeb.pdf

- Payment Strategies for LARC: http://www.astho.org/MCH/LARC/White-Bagging-Factsheet/

- Payment Strategies for LARC/Medicaid Policies: http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies/

11. Have robust referral networks and/or onsite teams available to address other medical issues, as well as social issues, that can impact health.

    Where people grow, live, work, and play (i.e. social determinants of health) impacts their health outcomes, including unintended pregnancy. Clinics should be aware of the social issues (e.g. violence, poverty, homelessness, neglect) people are facing in addition to (and that impact) health issues. Providers have a unique opportunity to screen for and assess social needs that may impact a person's ability to follow through with medical advice, or in the case of birth control, pick up a prescription. If social issues are identified, clinics need to have well-established referral partnerships with community-based or social service agencies.

Resources:

- Reproductive Health Equity for Young People, Social Determinants Resources: http://rhey.jsi.com/social-determinants/social-determinants-resources/

- Broadening the Base for Teen Pregnancy Prevention: Expanding Community Partnerships and Referral Networks: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15188&lid=3

- Teen Pregnancy Risk Assessment: www.enfield.gov.uk/youth/download/19/risk_assessment_checklist

- Partnership Assessment Tool: http://www.nccmt.ca/resources/search/10

- Social Determinants of Health PRAPARE Tool Training: http://www.nachc.org/wp-content/uploads/2016/08/Social-Determinants-of-Health.-Training-042815.pdf

12. Use a team-based health care delivery approach.

    Team-based care, which can include virtual teams, is defined as the "provision of health services to individuals, families, and/or their communities by at least two health care providers who work collaboratively with patients and their families to accomplish shared goals within and across settings to achieve coordinated, high-quality care." (ACOG) This approach is patient- or family-centered and always includes the patient as a team member. In addition to the patient and clinician(s), teams can include other clinic staff like patient navigators, peer educators, and community health workers. According to ACOG, the guiding principles of team-based care include:

- The patient is central and actively engaged.

- The team has a shared vision.

- Team members understand their role.

- All members are accountable for their own practice and to the team.

- Effective communication is key.

- Team leadership is situational and dynamic.

Team-based care may lead to better health outcomes, improved patient satisfaction and experiences, reduced costs, and increased provider satisfaction. (ACOG)

Resources:

- Collaboration in Practice: Implementing Team-Based Care: http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care

- Implementing Team-Based Care: https://www.stepsforward.org/modules/team-based-care

- Creating Patient-Centered Team-Based Primary Care: https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf

13. Use electronic health records (EHR) to support provision and communication of family-planning services through portals, triggers, templates, etc.

    EHRs have been identified as a way to coordinate medical care, improve communication with patients and other providers, reduce risks, and increase efficiency in the clinics. For example, assessing for pregnancy intention at every visit can be prompted through an EHR system. A clinic can then use the EHR data to track progress on this indicator for quality improvement. While every system is different, a clinic or health care setting can identify the types of alerts, templates, and portals necessary for their site.

    While the benefits of using an EHR are numerous, confidentiality concerns must be addressed with the EHR, especially for dependents. To ensure patient confidentiality while also using EHR, clinics should consider adopting the following practices:

- During appointment scheduling for sensitive services, electronically designate visits as 'confidential.'

- Turn off or limit access to visit reminders or appointment descriptions for sensitive services, consistent with patient preferences.

- Leverage the EHR to screen for patient's confidentiality preferences before every visit.

- Record all notes, histories, problem lists, medications, labs, and treatment plans as confidential, as needed.

- Ensure that the EHR identifies, classifies, and limits access to all confidential notes, histories, problem lists, medications, and treatment plans.

- Ensure patient confidentiality when providing medication lists.

- Filter and limit access to lab results for sensitive services.

- Coordinate billing procedures to ensure that EOBs are not sent for sensitive services.

Resources:

- Sensitive Health Care Services in the Era of Electronic Health Records: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiEo_Xr8_zSAhUJ9YMKHfskAKQQFggpMAA&url=http%3A%2F%2Fwww.connectccp.org%2Ffile_download%2Ff64773e7-403b-4888-b74e-67968ed8613a&usg=AFQjCNHNB1jI8GnPZSCTSoq1nHgWGfrK0A

- Adolescent Confidentiality and Electronic Health Records: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescent-Confidentiality-and-Electronic-Health-Records

- Social Determinants of Health PRAPARE Tool Training (eClinicalWorks): http://www.nachc.org/wp-content/uploads/2016/08/Social-Determinants-of-Health.-Training-042815.pdf

- Collecting Sexual Orientation and Gender Identity Data in EHRs: https://www.lgbthealtheducation.org/wp-content/uploads/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-EHRs-2016.pdf

14. Follow National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.[10]

The National Standards for CLAS are aligned with the Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy for Achieving Health Equity. The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individual and health and health care organizations to implement culturally and linguistically appropriate services.

The National Standards for CLAS include the following:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

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10 Fifteen standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Resources:

- National Standards for CLAS: https://www.thinkculturalhealth.hhs.gov/clas

- Resources About Culturally And Linguistically Appropriate Services (CLAS) And The National CLAS Standards: https://www.thinkculturalhealth.hhs.gov/resources

- CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care: https://www.minorityhealth.hhs.gov/assets/pdf/checked/CLAS_a2z.pdf

- National CLAS Standards: Fact Sheet: https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf

- CLAS Standards Implementation Tips: http://ww2.nasbhc.org/RoadMap/PracticeCompliance/CLAS%20Standards%20Implementation%20Tips.pdf

16. Use best practices for health literacy including transcreation of materials for different cultures.

    While many clinics and community-based organizations may have health education materials, many may not be culturally and linguistically relevant or easy to understand for our communities. Instead of simply translating materials into a different language, materials should be transcreated—a process of both translating and adapting the materials to be culturally relevant.

    In addition to transcreation, other communication best practices are included in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (see next best practice).

Resources:

- Quality Family Planning Guidelines (Appendix E): https://www.hhs.gov/opa/guidelines/clinical-guidelines/quality-family-planning/index.html

- Transcreation of Validated Smoking Relapse-Prevention Booklets for use with Hispanic Populations: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3804252/

- Culturally Adapting Health Intervention for Latinos: http://www.floridaliteracy.org/pdf-docs/adapting_latino.pdf

- Guide to Healthcare Translation: http://www.viadelivers.com/wp-content/uploads/2015/10/VIA-eBook-Beyond-Translation-Best-Practices-for-Healthcare.pdf

- The Health Literacy & Plain Language Resource Guide: https://www.amerihealthcaritas.com/pdf/health-literacy-guide.pdf

- Health Literacy Guidance and Tools: https://www.cdc.gov/healthliteracy/developmaterials/guidancestandards.html

17. Ensure hiring practices, job descriptions, and staff performance reviews incorporate job responsibilities related to contraceptive services and that all staff understand their role in supporting access ton contraception.

    Help build a skilled and competent workforce by including responsibilities related to contraceptive services in hiring practices, job description, and performance review. Staff, especially those who are not providing medical care, may be unaware of their role in helping patients access and receive appropriate care.

    All staff need to understand the goal of increasing access to contraceptives and what role they play in achieving that goal. Staff should have a basic understanding of the contraceptive services provided, clients who can receive these services, and requirements related to provision of and payment for services. This is especially important for front-line or call-center staff who often have the first encounter with a client.

Resources:

- Core Competencies for Adolescent Sexual and Reproductive Health Providers: Overview and Resources (Human Resources Toolkit on I drive)

- Upstream Training: http://www.upstream.org/our-training/

- LARC First Initiative—Module on Effective Staffing and Management: http://larcfirst.com/staffing.html

Provider and Staff Training[11]

A majority[12] of public clinics...

18. Conduct annual assessments for all providers and staff.

    • Assessments are based on CDC/OPA Quality Family Planning (QFP) Recommendations.

    • Assessments include knowledge, attitude, and skill questions as they relate to the QFP.

The QFP Guidelines are evidence-based recommendations on how to provide direct care to clients for contraceptive services. In order to best prepare providers and other clinical staff through training and professional development, one needs to understand staff knowledge, attitudes, and skills related to such recommendations.

Resources:

    • Assess Your Training: https://fpntc.org/assess-your-training

    • Upstream Training: http://www.upstream.org/our-training/

19. Provide ongoing, comprehensive training and professional development for all providers and staff related to the provision of contraceptive services.

    Clinics should offer and ensure staff are aware of available training. Training should be provided or offered to all staff, not just clinicians.

    The training offered is:

    • Customized based on the annual assessment of providers and staff.

    • Based on Quality Family Planning guidelines.

    • In alignment with standards of care set by providers' professional associations, such as ACOG, AAP, etc.

    • Developed and delivered using best practices principles that are grounded in behavioral science.

As trainings are designed and delivered, trainings should:

    • Offer hands-on practice;

    • Use adult-learning theories;

    • Provide evidence-based content;

    • Be responsive to provider/staff needs;

    • Use case studies; and

    • Be assessed for impact and improved.

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11   Providers and staff vary depending on the setting and may include clinicians, pharmacists, and non-licensed staff such as receptionist, medical assistants, health educators, billing staff, and others.

12   50% or more of publicly funded priority clinics (as identified by the BBC Initiative).

Follow-up on training, in the form of additional resources or access to technical assistance, is important.

Resources:

- Core Competencies for Adolescent Sexual and Reproductive Health Providers: Overview and Resources (Human Resources Toolkit on I drive)

- Develop Highly Productive and Positive Staff (Training and Professional Development): http://larcfirst.com/team_building.html

- Helpful Hints from the Colorado Initiative: https://powertodecide.org/what-we-do/information/resource-library/helpful-hints

- Assess Your Training: https://fpntc.org/assess-your-training

- Upstream Training: http://www.upstream.org/our-training/

20. Offer training annually for all providers and staff not previously trained in topics critical to effective delivery of high quality contraceptive care or as new guidelines are released. Topics should include, at a minimum, the following:

- Cultural Competency/Humility and Health Equity;

- Patient-centered, autonomous, and confidential care;

  - Relevant law and regulations and patient rights.

- High-quality, evidence-based patient-centered contraceptive counseling;

  - Reproductive coercion (from partner or family) paired with intimate partner violence screening.

- Pregnancy-intention screening;

- High-quality referrals for services not provided;

- Teen-friendly clinical practices;

- National Standards for CLAS in Health and Health Care;

- LARC insertion/removal and troubleshooting for complicated cases; and/or

- Billing and coding procedures to maximize patient confidentiality and contraceptive access (including billing and coding procedures for postpartum contraception access if relevant).

Trainings on providing high-quality contraceptive counseling should include:

- Shared decision making.

- Unconscious/implicit bias and ethics.

- Reproductive justice.

- Coercion and perceived coercion.

- Developmentally-appropriate and inclusive counseling methods.

Resources:

- Beyond the Pill (training): http://beyondthepill.ucsf.edu/

- LARC Mentor Program: http://www.ctcfp.org/larc/

- ACOG Clinical Training: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training

- Sister Song Reproductive Justice Training Program: http://sistersong.net/rj-training-and-leadership-development-programs/

- National Latina Institute for Reproductive Health training: http://latinainstitute.org/en/what-we-do/leadership-development/trainings

- One Key Question® Training: https://powertodecide.org/select360-consulting

- Programming for Training: A Resource Package for Trainers, Program Managers, and Supervisors of Reproductive Health and Family Planning Programs: https://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/programming_for_training.pdf

- Becoming a Culturally Competent Health Care Organization: http://www.diversityconnection.org/diversityconnection/membership/Resource%20Center%20Docs/Equity%20of%20Care%20Report%20FINAL.pdf

- Resources about Culturally and Linguistically Appropriate Services (CLAS) and The National CLAS Standards: https://www.thinkculturalhealth.hhs.gov/resources

- CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care: https://www.minorityhealth.hhs.gov/assets/pdf/checked/CLAS_a2z.pdf

- National CLAS Standards: Fact Sheet: https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf

- CLAS Standards Implementation Tips: http://ww2.nasbhc.org/RoadMap/PracticeCompliance/CLAS%20Standards%20Implementation%20Tips.pdf

- Reproductive Health E-Learning Courses (interactive, web-based courses for providers): https://prh.org/programs/e-learning-courses/

- Adolescent Reproductive and Sexual Health Program (comprehensive, evidence-based curriculum for residency programs, providers, and other professionals who serve adolescents): https://prh.org/teen-reproductive-health/arshep-explained/

- Providing Quality Contraceptive Counseling & Education: A Toolkit for Training Staff: http://www.cardeaservices.org/resourcecenter/providing-quality-contraceptive-counseling-education-a-toolkit-for-training-staff

- Core Competencies for Adolescent Sexual & Reproductive Health, California Adolescent Sexual Health Workgroup: http://ashwg.org/core-competencies-and-data-collaboration-for-service-integration/

- Best Practices for Youth-Friendly Sexual and Reproductive Health Services in Schools: http://www.advocatesforyouth.org/storage/advfy/documents/bp-youth-friendly-services.pdf

- Protecting Confidentiality for Individuals Insured as Dependents: https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents

- Developing a Referral System for Sexual Health Services: http://connectionsforstudentsuccess.org/index.php/referral-kit-download/referral-kit-download-2

- Referrals and Linkages to Youth-Friendly Health Care Services: https://www.hhs.gov/ash/oah/sites/default/files/referrals_and_linkages_to_youth_friendly_health_care.pdf

- Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings: https://www.acog.org/-/media/Departments/Violence-Against-Women/Reproguidelines.pdf

- Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention: http://www.feministcenter.org/RCtoolkit.pdf

- Redefining Safety Planning in the Context of Reproductive Coercion: Integrating Assessment for Emergency Contraception Within Domestic Violence Shelter and Advocacy Programs: https://www.futureswithoutviolence.org/redefining-reproductive-coercion/

- Adolescent Confidentiality and Electronic Health Records: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescent-Confidentiality-and-Electronic-Health-Records

- The Postpartum Intrauterine Device Trainer's Manual: https://www.engenderhealth.org/files/pubs/family-planning/PPIUD_Trainers-Manual.pdf

- Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm?s_cid=mm6026a3_w

- Improving Contraceptive Counseling through Shared Decision-Making Curriculum: http://innovating-education.org/2016/03/2743/

- Decision-Making Tool for Family Planning Clients and Providers: http://www.who.int/reproductivehealth/publications/family_planning/Technical_adaptation_guide.pdf

- The SHARE Approach: https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

- What is Reproductive Justice and what does it have to do with nursing?: https://rhnursing.org/resource/reproductive-justice-nursing/

- Upstream (training): http://www.upstream.org/

Additional topical resources can be found in previous best practices.

21. Offer additional training or resources on other important topics including:

- Working with diverse communities within their region and understanding their specific community dynamics;

- Importance of contraceptive initiative/contraception access;

- Adolescent development (including cognitive/neurological development);

- Behavior-change theory;

- Trauma-informed care; and/or

- Communication skills, specifically how to communicate with patients.

Resources:

- Adolescent Health Curriculum for Providers: https://prh.org/teen-reproductive-health/arshep-explained/

- CAI Staff E-Learning Modules: https://www.capital.org/eweb/DynamicPage.aspx?site=cai&webcode=cai-training&wps_key=67872df2-6ff6-44dd-8fd2-d5f7479da94b

- Upstream: http://www.upstream.org/

- Reproductive Health Access Project: Trauma-Informed Pelvic Exam (patient-centered techniques to improve pelvic exam experience): http://www.reproductiveaccess.org/resource/trauma-informed-pelvic-exams/

- 10 Things to Create Inclusive Health Care Environments: http://www.lgbthealtheducation.org/wp-content/uploads/Ten-Things-Brief-Final-WEB.pdf

- National Standards for CLAS: https://www.thinkculturalhealth.hhs.gov/clas

- Promising Practices and Model Programs: Trauma-Informed Approaches to Working with Survivors of Domestic and Sexual Violence and Other Trauma: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2016/01/NCDVTMH_PromisingPracticesReport_2015.pdf

- A Trauma Informed Approach for Adolescent Sexual Health: https://icahtoolkit.files.wordpress.com/2014/10/a-trauma-informed-approach-for-adolescent-sexual-health.pdf

- General Development Guidelines: https://www.adolescenthealth.org/Topics-in-Adolescent-Health/Physical-and-Psychosocial-Development/Clinical-Care-Guidelines/General-Development-Guidelines.aspx

- Training to Advance Physicians' Communication Skills: https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6gtraining.html

Additional resources can be found in previous best practices.

22. Have a clear plan for mentoring/proctoring and skills practice for IUD/implant insertion and removal.

Beyond initial clinical skills and knowledge training, clinics should ensure quality LARC services through ongoing provider trainings, supervision, and skills practice. Ongoing mentoring and supervision can lead to greater provider retention and practice of LARC-related skills. LARC mentoring/proctoring and skills practice can be achieved by implementing ongoing supervision systems.

More experienced and skilled providers should be identified as LARC mentors, giving less experienced providers the opportunities to practice LARC skills with supervision, receive mentorship and support, report problems, and ask questions. Clinics should consider implementing post-training protocols, such as clinical skills retention assessments, general assessments of LARC removal and insertion techniques, and opportunities for reflection and review. For IUDS, specifically, available resources include relevant IUD-training materials and IUD Counseling and Clinical Skills Assessments. IUD-training programs can also apply behavior modeling, competency-based evaluation of performance, and competency for both counseling and skills.

Specifically for the implant, providers must coordinate training with the pharmaceutical manufacturer (Merck) before they are allowed to purchase the device.

Resources:

- The LARC Mentor Program: http://www.ctcfp.org/larc/

- IUD Guidelines for Family Planning Programs: http://pdf.usaid.gov/pdf_docs/Pnadi156.pdf

- Programming for Training: A Resource Package for Trainers, Program Managers, and Supervisors of Reproductive Health and Family Planning Programs: https://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/programming_for_training.pdf

- Information about the contraceptive implant, including a link to request training: https://www.merckconnect.com/nexplanon/overview.html?hcpUser=yes

23. Extend liability coverage for providers to training for LARC, including when providers go offsite for training.

Ideally, a clinic would have senior, more experienced clinicians on site to provide both training and mentoring of less-experienced clinicians for IUD and implant insertion and removal. When this is not possible, clinicians must seek training/mentoring at other locations, which can create challenging bringing of medical liability coverage issues.

Federally Qualified Health Centers (FQHCs) that receive federal funding through the Health Resources and Services Administration are able to apply for the Federal Tort Claims Act (FTCA) to provide liability coverage to their clinicians. However, liability coverage is limited to the FQHC-approved provider who is conducting a standard required service at the FQHC site and with a FQHC patient. IUD and implant insertion and removal would be considered a standard required service. The issue becomes a problem if the training and practice are with patients who are not FQHC patients and/or offsite at a different clinic. For example, if the FQHC provider goes offsite to another clinic to provide services, even for the purposes of training, this coverage would not apply.

When a clinic is not able to extend liability coverage, training can be provided via a simulator and/or onsite at their FQHC with FQHC patients. FQHC's are able to apply for a one-time exception through a Particularized Determination if it is not possible to provide onsite or training on simulators. After applying, the clinic will receive a response within 30 days. Tips on requesting a Particularized Determination can be found here.

Resources:

- Federal Tort Claims Act: https://bphc.hrsa.gov/ftca/index.html

- Particularized Determination Tip Sheet: https://bphc.hrsa.gov/ftca/particularizeddeterminationtipsheet.pdf

Policy

State and local policies have an impact on the ability of people to access the full range of contraceptive methods. Policy is broadly defined for the purposes of this domain, and includes legislative as well as regulatory and administrative actions that can reduce barriers to contraception.

There is considerable uncertainty in the current federal policy environment when it comes to birth control coverage and access. This includes ongoing threats from Congress and the Administration when it comes to overall health coverage, as well as specific policies related to contraception and a fluid legal landscape as well. Therefore, it is uncertain whether some of the federal policy options listed below will continue to be available. In addition, state policies are evolving rapidly, some to protect access to contraception, others to limit it. Before delving into policy options identified in this guide, it will be important to check the latest federal and state policy situation. As with any policy options, the feasibility of implementing specific policies in your state will vary, depending on the policy and political environment.

The policies listed below have been grouped into categories. Within each category, the policies are listed in a general order of potential impact to help guide the prioritization process.

Education

1. State and/or local policies require science-based, medically-accurate, and age-appropriate sexual health education, including information on the full range of contraceptive methods, be provided in appropriate settings (e.g., colleges, schools, child welfare programs, etc.).

    This will require you to explore policies within various institutional settings in your community. For example, examine state and local school board policy related to sexual health education. There may be legislation related to this type of work, or regulations may only exist within school board policy for particular districts.

State Examples:

*   North Carolina Healthy Youth Act of 2009: http://www.ncleg.net/Sessions/2009/Bills/House/PDF/H88v8.pdf

*   Mississippi and Arkansas legislation that addresses unplanned pregnancy prevention in higher education:

    *   http://billstatus.ls.state.ms.us/documents/2014/pdf/SB/2500-2599/SB2563SG.pdf

    *   ftp://www.arkleg.state.ar.us/acts/2015/Public/ACT943.pdf

    *   http://astho.org/Maternal-and-Child-Health/Arkansas-Focuses-on-College-Students-to-Lower-Teen-Pregnancy-and-Birth-Rate/

Policies related to education in other settings, such as child welfare systems, may be found in state legislation, but are more likely found in county/state agency policies and practices.

State Examples:

*   New York State: http://ocfs.ny.gov/main/policies/external/OCFS_2011/ADMs/11-OCFS-ADM-09%20Reproductive%20Health%20and%20Services%20for%20Youth%20in%20Foster%20Care.pdf

- California New Health Rights And Social Worker And Probation Officer Responsibility To Educate Foster Children And Non-Minor Dependents On Foster Youth Personal Rights: http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-38.pdf

Resources:

- State Policies on Sex Education: http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx

- John Burton Foundation – Senate Bill 245: Reducing Unintended Pregnancy Among Foster Youth: http://www.jbaforyouth.org/sb-245-reproductive-health/

- State Policies to Educate College Students about Unplanned Pregnancy: https://powertodecide.org/what-we-do/information/resource-library/state-policies-to-educate-college-students

Access to Providers

2. Public and private plans guarantee strong access to providers with specialized training in contraceptive counseling, including OB/GYN providers, and who offer the full range of contraceptive methods onsite.

The issue of network adequacy is a concern in the broader health care conversation as well as one within the context of providing high quality and comprehensive contraceptive care. Specifically, narrow provider access has emerged as one industry response to containing rising medical costs. Related to contraceptive care, it is critical to ensure that plans include an adequate number of providers who offer the full range of contraceptive methods. There are no national standards for network adequacy with regard to contraceptive care and it is left to states to determine how to ensure network adequacy. According to Medicaid Managed Care Rules, states must create time and distance standards for eight provider types, including primary care providers and OB/GYNs. The National Health Law Program (NHeLP) encourages state advocates to work closely with the states to ensure they develop meaningful standards that will support as much access as possible for clients/beneficiaries. Also, while family planning providers are not covered under the time and distance standards, the same Medicaid Managed Care rule did include a requirement that states ensure each plan's network "includes sufficient family planning providers to ensure timely access to covered services.

Resources:

- Network Adequacy In Maryland: A Report On Provider Directories And Women's Access To Health Care Services: https://nationaldisabilitynavigator.org/wp-content/uploads/state-resources/MDWC_Report-OBGYN-Network-Adequacy_11-13-15.pdf

- Marketplace Plans' Provider Networks Are Just Not Adequate Without Family Planning Centers (maps different standards by state): https://www.guttmacher.org/gpr/2015/07/marketplace-plans-provider-networks-are-just-not-adequate-without-family-planning?utm_source=Master+List&utm_campaign=0e6bacce01-RHIC_GPR11s_2017_04_03&utm_medium=email&utm_term=0_9ac83dc920-0e6bacce01-260649673

- Ensuring Compliance with Network Adequacy Standards: Lessons from Four States: http://www.urban.org/research/publication/ensuring-compliance-network-adequacy-standards-lessons-four-states/view/full_report

- Issue Brief 5: Medicaid Managed Care Final Regulations and Reproductive Health: http://www.healthlaw.org/publications/browse-all-publications/Brief-5-MMC-Final-Reg-Repro-Health#.WaA9nyiGPcs

Access to Contraception Regardless of Location, Provider, and Type of Method

3. Public and private payers cover an extended supply (at least 12 months) of self-administered hormonal contraception (i.e. for birth control pills, rings, or patches) at one time, when prescribed and/or dispensed by a provider.

   Research demonstrates that women who receive a 12-month supply of self-administered hormonal contraception have higher compliance and continuation rates, and one study found that providing a 12-month supply can reduce the odds of having an unplanned pregnancy by 30% and the odds of an abortion by 46%. Many insurance plans limit the provision of contraception to one or three months requiring the client to go through steps to refill the prescription frequently.

State Examples:

As of June 2017, 12 states, including Washington, D.C. have signed into law legislation that would require private health plans to an extended supply (usually 12 months) of self-administered contraception. This fact sheet provides an overview of the laws in each of those states: https://thenationalcampaign.org/sites/default/files/resource-primary-download/extended-supply-of-contraception.pdf.

Resources:

- State Policies on an Extended Supply of Contraception: https://powertodecide.org/what-we-do/information/resource-library/extended-supply-contraception

- Making a one-year supply of birth control a national standard: https://bixbycenter.ucsf.edu/news/making-one-year-supply-birth-control-national-standard

- States Must Act to Shore Up the Federal Contraceptive Coverage Guarantee: https://www.guttmacher.org/gpr/2017/02/states-must-act-shore-federal-contraceptive-coverage-guarantee

4. Policies allow for the provision of contraception by any willing and qualified provider including pharmacists.

   In an effort to increase access to some forms of contraception, six states (California, Hawaii, Maryland, New Mexico, Oregon, and Tennessee) have enacted legislation and/or regulations giving pharmacists the authority to prescribe and dispense self-administered hormonal contraceptives. Subsequent regulations have been promulgated by the state board of pharmacy (which may require pharmacists to take a continuing education course to be certified in this area). While there is some concern that this will not provide as much flexibility as over-the-counter access to contraceptive pills (which would require FDA approval), it will allow some women to access some a methods (typically pill, patch, and ring) if they are unable to access a physician or advanced practice provider with prescribing authority.

   State pharmacy associations, at least in states where these laws have passed, have been supportive of these expansions. Washington State found that pharmacists effectively screened, counseled and provided birth control to women in the study. In fact, 12 months after initiating, 70% of women reported that they were continuing to use the method they selected.

As states consider this policy option, there factors to consider, such as whether pharmacies will be able to provide a private space for counseling (other concerns are addressed in Best Practice #4 under Reimbursement policies specific to providers).

State Examples:

- Oregon: https://www.oregon.gov/pharmacy/Pages/ContraceptivePrescribing.aspx#Tool-Kit_Resources

- California's Protocol for Pharmacists Furnishing Self-Administered Hormonal Contraception: http://www.pharmacy.ca.gov/licensees/hormonal_contraception.shtml

- Washington: http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/2681-S2.SL.pdf#page=1

Resources:

- Key State Policies at a Glance: https://powertodecide.org/what-we-do/information/resource-library/key-state-policies

- Briefly: State Policies to Increase Information About and Access to Contraception: https://powertodecide.org/what-we-do/information/resource-library/briefly-state-policies

5. If gaps are created by individual providers and facilities who object to birth control, they are addressed by requiring all providers (including pharmacists) and health care facilities to provide same-day referrals in the case of refusal.

   In general, these policies are regulations set by boards within each state or by the governing body for a particular facility or health system. There may be legislation requiring the board to have a particular policy in place.

Resources:

- Federal and State Policies Allowing Nonparticipation in Reproductive Health Care: https://www.guttmacher.org/gpr/2000/02/refusing-participate-health-care-continuing-debate

- Pharmacist Conscience Clauses: Laws and Information: http://www.ncsl.org/research/health/pharmacist-conscience-clauses-laws-and-information.aspx

6. Policies related to school- and college-based health centers allow for the provision of all methods of contraception onsite.

   These policies could be set by separate health care systems, or the school systems themselves. In some cases, states have passed legislation that restricts the provision of contraception within school-based health centers. If no such legislation exists within a state, we would recommend looking within particular district regulations to determine the governing regulations. It is also the case that particular districts may not have any school-based health centers within their schools, or that school based health centers are staffed by practitioners who don't have authority to administer the full range of methods.

Resources:

- Meeting the Sexual and Reproductive Health Needs of Adolescents in School-Based Health Centers: https://www.guttmacher.org/gpr/2015/04/meeting-sexual-and-reproductive-health-needs-adolescents-school-based-health-centers

- Nurses' Authority to Prescribe or Dispense: https://www.guttmacher.org/state-policy/explore/nurses-authority-prescribe-or-dispense

7. All emergency rooms (ER) are required to dispense emergency contraception (EC) to sexual assault survivors.

Due to the time sensitive nature of providing EC, it is critical that women are able to access EC as quickly as possible following unprotected sex. This applies to women who have experienced sexual assault as well. As of June 2017, 13 states and the District of Columbia were required to provide EC in the ER at the request of a sexual assault victim. Seventeen states and D.C. are required to provide information about EC to victims of sexual assault. Additional information about elements of a successful law regarding EC in the ER is available here: https://www.nwlc.org/sites/default/files/pdfs/ECsexualassaultAug09.pdf

Resources:

- Emergency Contraception: https://www.guttmacher.org/state-policy/explore/emergency-contraception

- Emergency Contraception: https://nwlc.org/resources/emergency-contraception/

8. Contraception access and reimbursement are not restricted in state laws and regulations regarding telemedicine.

Sizable numbers of women live in areas with limited access to reproductive health services. In fact, a study found that in 2010, 49% of counties lacked an OB-GYN. Telemedicine and telehealth provide an opportunity to connect women in areas with limited access to providers to contraceptive counseling and provision services. Nearly all states have a definition in law, regulation, or through the Medicaid program for telehealth or telemedicine with respect to services covered and reimbursed. Ensuring that access to contraception via telemedicine—both through counseling and screening as well as provision of methods— could support increased access particularly for women in underserved locations.

Resource:

- Telemedicine for Reproductive Health: http://www.pcori.org/sites/default/files/PPFA-Summit-Topic-Brief-Telemedicine-for-Reproductive-Health.pdf

- Building Bridges: Innovation in Telemedicine Use for the Provision of Reproductive Health Care: http://rhtp.org/wp-content/uploads/2016/08/RHTPBuildingBridges-InnovationinTelemedicineUsefortheProvisionofReproductiveHealthCare.pdf.

Medicaid/ Public Insurance Coverage Programs

9. Medicaid is expanded as the Affordable Care Act (ACA) allows and states continue or adopt Medicaid Family Planning (FP) expansions either through a waiver or State Plan Amendment (SPA).

    Medicaid expansion increases the number of reproductive-age women who have access to full scope health coverage, which includes the full range of contraceptive methods without cost-sharing. Especially for states that haven't adopted Medicaid expansion, Medicaid Family Planning expansions (through waivers or SPA) continue to be important strategies to provide contraceptive services to women who are not eligible for full Medicaid services. For those states who have expanded Medicaid, each state needs to assess its own unique circumstances to determine if it makes sense to continue a family planning expansion. Most of the states that expanded Medicaid and had a family planning program prior to the ACA chose to keep their separate family planning program. Reasons for doing so include providing dedicated, high-quality family planning services, and serving as a safety-net for those who don't qualify for full-scope Medicaid, but may not be eligible for or able to afford insurance through the marketplace.

Resources:

-   Medicaid Family Planning Eligibility Expansions: https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions

-   Status of State Action on the Medicaid Expansion Decision: http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

-   How Medicaid Expansion Benefits Maternal and Child Health: http://www.healthlaw.org/issues/reproductive-health/how-medicaid-expansion-benefits-maternal-and-child-health#.WT_fDmjyvcs

-   Medicaid Family Planning Programs: Case Studies of Six States After ACA Implementation: https://www.kff.org/womens-health-policy/report/medicaid-family-planning-programs-case-studies-of-six-states-after-aca-implementation/

10. All of the state's Medicaid eligibility pathways (programs) are aligned to cover at least one birth control method in each of the 20 categories (18 for women and two for men) identified in the FDA Birth Control Guide.

    There are 18 categories of contraceptives identified for women and two for men in the FDA Birth Control Guide. At least one type of birth control in each category should be covered with no cost to the patient. This will allow consumers the ability to have choice in their birth control method.

State Examples:

A survey of 40 states and Washington D.C. found that as of July 2015, many states, but not all, had aligned coverage of prescription contraceptives across all of their Medicaid programs.

State Medicaid programs include the following:

-   "Traditional" Medicaid,

-   Medicaid expansion as allowed under the ACA, and

-   Family Planning (FP) Expansions (i.e. FP waiver or State Plan Amendment/SPA).

Resources:

- Medicaid Coverage of Family Planning Benefits: Results from a State Survey: http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey

- Payment Strategies for LARC/Medicaid Policies: http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies/

11. States provide individuals with the option to complete an application for family planning services-only.

Under the ACA, all states are required to have a single, streamlined application for all insurance affordability programs (Medicaid, Children's Health Insurance Plan, and Premium Tax Credits to subsidize the cost of buying insurance in the state/federal marketplace). In addition, the "no wrong door" concept adopted by the ACA allows eligibility to be evaluated for all three insurance affordability programs, regardless of whether an application is started through the Medicaid state agency or the state/federal marketplace. However, the single, streamlined application is longer and more burdensome than an application specifically for family planning services. This can make it harder for people who are only interested in applying for family planning services, and for family planning providers to assist with the application. Having an application for family-planning services only will make it easier and less complicated to for both individuals and providers.

State Examples:

- In 2016, South Carolina proposed an amendment to the South Carolina Title XIX (Medicaid) State Plan to reinstate a Family Planning-Only application, allowing individuals to apply only for these limited services.

- California's family planning only application allows eligible applicants to enroll at their provider's office and immediately secure coverage for that visit.

States that rely on the Federally Facilitated Marketplace (FFM) (most states do) should also consider that the FFM is not able to provide eligibility determinations for family planning programs. In addition, states relying on the FFM delegate to it the authority to "assess" or to "determine" eligibility. In states that allow the FFM to "assess" Medicaid eligibility, applicants who are found eligible for Medicaid are transferred to the Medicaid state agency so the state can conduct eligibility determinations for all Medicaid categories. However, this opportunity is lost for applicants in states that allow the FFM to conduct full eligibility determinations—as the files of those who are determined to be ineligible for Medicaid are not sent over to the Medicaid state agency. Thus, states with a FFM may consider having a family planning services-only applications available to applicants who are interested only in those services.

Resources:

- SC-16-0001 SPA Approval Letter: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SC/SC-16-0001.pdf

- State Health Insurance Marketplace Types, 2017: http://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

- Medicaid Family Planning Programs: Case Studies of Six States After ACA Implementation: http://www.kff.org/report-section/medicaid-family-planning-programs-case-studies-of-six-states-after-aca-implementation-report/

- Medicaid and CHIP Marketplace Interactions: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-and-the-marketplace/index.html

- CMCS Informational Bulletin, Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace"): https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf

12. State has received approval, through a State Plan Amendment, to implement Medicaid/Children's Health Insurance Program (CHIP) coverage of lawfully residing immigrant children and pregnant women without a five-year waiting period.

    In 2009, the Immigrant Children's Health Improvement Act (ICHIA) was passed as part of the reauthorization of the Children's Health Insurance Program (CHIP). This gave states the ability to extend federally funded Medicaid/CHIP coverage to legally residing pregnant women and children who were previously subject to the five-year waiting period required under the 1996 welfare reform act (Personal Responsibility Work Opportunity Reconciliation Act).

State Examples:

As of 2017, 22 states plus D.C. have taken the option to cover pregnant women under ICHIA, and 30 states plus D.C. have taken the option to cover children under ICHIA. This represents a diverse group of red and blue states, with Florida and Utah being the most recent states to take up the ICHIA option to cover children in 2016.

Resources:

- Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women: http://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

13. The state sets aside funds to cover populations excluded from federal health insurance programs.

    Immigrants face a number of risk factors associated with sexual and reproductive health, which are exacerbated by lack of access to health care. To help overcome such barriers and increase positive health outcomes, states have enacted a variety of policies to cover immigrants.

State Examples:

Fourteen states and D.C. use state funds to provide public insurance to qualified immigrants (who are not pregnant nor children) under the five year Medicaid ban; 16 states and D.C. use state funds to cover select categories of non-qualified immigrants, and five states and D.C. provide public health insurance to all deferred action recipients who meet income-eligibility requirements.

Resources:

- Immigrant Access to Health and Human Services: Final Report: http://www.urban.org/research/publication/immigrant-access-health-and-human-services-final-report/view/full_report

- Policy Solutions to Improving Access to Coverage for Immigrants: https://www.nationalfamilyplanning.org/file/documents---policy-briefs/ImmigrationReport.pdf

- Health Coverage and Care for Immigrants: http://www.kff.org/report-section/health-coverage-and-care-for-immigrants-issue-brief/

- Medicaid Family Planning Programs: Case Studies of Six States After ACA Implementation: https://www.kff.org/womens-health-policy/report/medicaid-family-planning-programs-case-studies-of-six-states-after-aca-implementation/

14. There is suspension rather than disenrollment of Medicaid benefits for individuals who become involved in the justice system.

   In an effort to ensure continuity of care, suspending rather than dis-enrolling individuals in Medicaid if an individual becomes involved in the justice system, is an important practice. In particular, it can be important when considering the context of contraceptive care and the need for continuous coverage in order to ensure continuous use of a method. In addition, it is helpful to keep in mind recent Medicaid guidance on justice-involved individuals reentering their communities.

Resources:

- CMS SHO#16-007 RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

- CMS S&C 16-21- ALL RE: Updated guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf

- How and When Medicaid Covers People Under Correctional Supervision: http://www.pewtrusts.org/~/media/assets/2016/08/how_and_when_medicaid_covers_people_under_correctional_supervision.pdf

- Medicaid Suspension Policies for Incarcerated People: 50-State Map: http://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map

Reimbursement/Payment

Ensuring that reimbursement policies provide adequate coverage for the full range of contraceptive methods can reduce barriers to consumer access of these methods. Given the breadth of contraceptive methods, and the wide range in costs, reimbursement policies can also be barriers to ensuring full choice that is free of coercion. Reimbursement challenges can most often restrict access to methods with higher up-front costs such as the IUD and implant. To help alleviate reimbursement challenges, the University of California San Francisco (UCSF), in partnership with the NHeLP, National Women's Law Center (NWLC), National Family Planning & Reproductive Health Association (NFPRHA), and the American College of Obstetricians and Gynecologists (ACOG) developed a reimbursement guide for providers which can be accessed here: http://larcprogram.ucsf.edu/.

Reimbursement policies specific to methods

15. Reimbursement methods account for the full value of all family planning methods (including the cost of the contraceptive, relevant dispensing, and/or insertion costs) while respecting patient autonomy.

Appropriate reimbursement is critical to ensuring there is not a disincentive for providing a particular method of birth control. In order to ensure that patient autonomy and decision-making is central to method selection, it is also important to ensure that particular methods are not incentivized over others. Reimbursement policies should apply to public as well as private insurance plans.

State Examples:

- California Medicaid: Aligned the dispensing fee for LARC methods with other contraceptives so that providers are not penalized for providing LARC to patients who choose them. For example, eligible entities may bill $12 per unit of contraceptives dispensed. One month of oral contraceptives equals one unit and eligible entities may bill for a maximum allowable of 13 units. They can bill for more units for longer acting contraceptives (e.g. three units per injection of Medroxyprogesterone Acetate, and 36 units per IUD or implant) to correspond with the amount of time for which those methods are active.

- Washington Medicaid: Increased reimbursement for LARC insertion and removal to reflect the fact that it is a value-based intervention due to the cost-savings that result from decreases in unplanned pregnancy.

Resources:

- Intrauterine Devices & Implants: A Guide to Reimbursement: http://larcprogram.ucsf.edu/

- Payment Strategies for LARC/Medicaid Policies: http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies/

- CDC Reimbursement Guidelines: https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-pregnancy.pdf

- CMCS Informational Bulletin, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf

16. Covering costs of insertion and removal of IUDs and implants regardless of reason for procedure. This includes costs associated with removal when a patient loses coverage.

In order to ensure full patient autonomy, it is critical that covering the costs of insertion and removal of IUDs and implants is done regardless of reason for insertion or removal. This should also apply when patients switch methods regardless of reason. Research suggests that satisfaction with IUDs and implants is high, but it is also the case that women may choose to discontinue these methods for various reasons before the approved expiration date. If you are addressing this issue, you need to take into account the various policies regarding Reasonable Medical Management to ensure there are no cost barriers to removal and/or insertion of a different device. It is also the case that all commercial plans and Medicaid expansion plans subject to the ACA's contraceptive coverage requirements must cover LARC method removal without cost-sharing. With regard to Medicaid, federal regulation requires that beneficiaries be free to choose, without any coercion, their method of family planning. Freedom of choice extends to an individual's decision to start/insert and stop/remove a method.

Resource:

- Intrauterine Devices and Implants: A Guide to Reimbursement—Removal http://larcprogram.ucsf.edu/removal

- Intrauterine Devices & Implants: A Guide to Reimbursement: https://www.nationalfamilyplanning.org/file/documents----reports/LARC_Report_2014_R5_forWeb.pdf

17. Payer sources do not prohibit same-day access to all contraceptive methods.

Same-day access to all contraceptive methods may be particularly challenging for methods with the highest up-front costs such as IUDs and implants. When these methods are covered as a medical benefit this often gives providers the ability to purchase the devices in advance to have on the shelf and bill for reimbursement once the device has been placed. This will require some capital outlay on behalf of the provider. When these methods are covered as a pharmacy benefit, in general, this means that a particular device must be ordered for a particular patient thus making same-day provision a challenge. More information about the various ways that these methods are covered as well as information about how to predict stocking needs is available here: http://larcprogram.ucsf.edu/stocking.

State Example:

- Beginning in October 2014, Illinois Medicaid began allowing reimbursement for an evaluation/management visit on the same day as LARC insertion or removal procedures.

Resources:

- Intrauterine Devices and Implants: A Guide to Reimbursement: http://larcprogram.ucsf.edu/

18. Payer sources do not impede access to either a) immediate postpartum or b) immediate post-abortion provision of any contraceptive method.

Immediate postpartum or immediate post-abortion can be an ideal time to provide contraception. Specifically, in cases of the provision of an IUD or implant, the immediate postpartum or immediate post-abortion time can be an important opportunity if the patient is seeking that method at that time. However, in some cases, it can be challenging to provide this service during this time period due to reimbursement challenges. For instance, providing a single global payment for labor and delivery can be a disincentive for providers to insert LARC devices immediately postpartum because the providers are not receiving reimbursement for the insertion and/or the device. The Association of State and Territorial Health Officials (ASTHO) has established a Learning Community to build states' capacity to increase access to contraception, including a focus on postpartum IUD and implant access. More information about how to reduce these barriers is available here: http://www.acog.org/LARCimmediatepostpartum.

ACOG recommends having LARC methods available immediately after birth and abortion. However, state and federal regulations that prohibit using state or federal funds for abortion care complicate the process for billing a LARC that is provided subsequent to abortion services, as noted in a report from the Center for American Progress. As a result, providers may be apprehensive about billing public programs for post-abortion LARC. The authors suggest that state and federal guidance should be issued that clarifies that LARCs can be provided post-abortion without violating funding prohibitions and how best to do so.

State Examples:

- South Carolina: In 2012, South Carolina became the first state to institute a Medicaid policy enabling hospitals and providers to receive full reimbursement for the LARC device and the physician insertion procedure fee when women received a LARC postpartum, before being discharged from the hospital. Twenty-six states and Washington, D.C. now have similar Medicaid policies.

Resources:

- ACOG Immediate Postpartum LARC: https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC

- Immediate Postpartum LARC Resource Digest: https://www.acog.org/-/media/Departments/LARC/IPPLARCResourceDigestReplaceable.pdf?dmc=1&ts=20170705T1458186710

- Post-abortion Contraception: Emerging Opportunities and Barriers: https://www.guttmacher.org/gpr/2017/10/postabortion-contraception-emerging-opportunities-and-barriers

- "Contraceptive Access Now" and the Expansion of LARC in Delaware: http://www.nashp.org/wp-content/uploads/2017/04/NASHP_LARC_Delaware-updated.pdf

- CMCS Informational Bulletin, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf

- Trends in Repeat Births and Use of Postpartum Contraception Among Teens—United States, 2004–2015: https://www.cdc.gov/mmwr/volumes/66/wr/mm6616a3.htm

- The Case for Immediate Postpartum LARC: http://core.arhp.org/search/searchDetail.aspx?itemId=12483

19. Medicaid and private insurers cover FDA-approved over-the-counter (OTC) contraception and supplies without a prescription and without limiting the number of cycles allowable. This includes, but is not limited to: emergency contraception (EC), male and female condoms, the sponge, and spermicide.

    Coverage of over-the-counter contraception and supplies is limited across the states. State Medicaid programs that do cover OTC contraception often require a prescription. This can cause unnecessary barriers for patients needing access to condoms, EC, the sponge, and spermicide.

State Example:

Maryland has enacted a state law requiring coverage for OTC (without a prescription) and prescription contraception without cost sharing.

Resources:

- Medicaid Coverage of Over-the-Counter Contraceptives (2015): http://www.kff.org/womens-health-policy/state-indicator/medicaid-coverage-of-over-the-counter-contraceptives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

- Medicaid Coverage of Family Planning Benefits: Results from a State Survey: http://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/

20. Policies allow outpatient clinics to order IUDs or implants for specific patient from a specialty pharmacy, and bill the device to the patient's insurance (also known as white-bagging) and complementary buy-back programs exist for unused devices.

   If providers are hesitant to purchase IUDs and implants, this policy and practice reduces financial risk on providers, as they are not charged at any time for the device. However, it has the downside of preventing same day patient access.

State Example:

Beginning in 2014, South Carolina began allowing providers enrolled with Fee-For-Service FFS Medicaid to be reimbursed for outpatient utilization of LARC through the pharmacy program. In addition, all six of the state's Medicaid managed care plans include this in their capitated rates, and participate in the specialty pharmacy benefit.

Resources:

- South Carolina Department of Health and Human Services, Payment of LARCs through the Pharmacy Benefit: https://www.scdhhs.gov/press-release/payment-larcs-through-pharmacy-benefit

- South Carolina Birth Outcomes Initiative, LARC Outpatient White Bagging: Status of Policy Change: http://www.astho.org/Prevention/ASTHO-LARC-White-Bagging-SC/

- Payment Strategies for LARC/White Bagging: http://www.astho.org/MCH/LARC/White-Bagging-Factsheet/

- UCSF: Intrauterine Devices & Implants: A Guide to Reimbursement: http://larcprogram.ucsf.edu/obtaining-supplies#pharmacy

Reimbursement policies specific to providers

21. All public and private sources of payment should include, and fairly fund or reimburse, effective providers of family planning services. No provider's participation in a plan or program should be barred or limited based on reasons unrelated to its qualifications to effectively provide family planning services. Over the past few years, some states have tried to restrict the kinds of providers that are eligible to be participate in safety-net programs (state-funded family planning programs, Medicaid, and Title X). In 2016, CMS issued a State Health Official Letter, reminding states that federal regulations cannot prohibit providers from participating in the Medicaid program for any reason aside from their "capability to perform the required services in a professionally competent, safe, legal, and ethical manner—or the ability of the provider to appropriately bill for those services."

   With regard to Title X, the same federal protections do not exist, and a number of states have enacted measures to prohibit Title X funds from going to Planned Parenthood or any abortion provider-despite the fact that Title X funds have never been eligible to pay for abortion. In December 2016, the Obama Administration issued guidance in an effort to extend federal protections to Title X. However, in March 2017, Congress overturned this guidance through a process provided in the Congressional Review Act.

Resource:

- CMS State Medicaid Director Letter SMD # 16-005, Clarifying "Free Choice of Provider" Requirement in Conjunction with State Authority to Take Action against Medicaid Providers: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf

- Recent Funding Restrictions on the U.S. Family Planning Safety Net May Foreshadow What Is to Come: https://www.guttmacher.org/gpr/2016/12/recent-funding-restrictions-us-family-planning-safety-net-may-foreshadow-what-come

22. Mechanisms exist to encourage/require all public and private providers that serve women of reproductive age to include screening and counseling about pregnancy intention or reproductive life planning.

   Possible mechanisms include the following:

   - Adopting appropriate quality measures,

   - Issuing state Medicaid guidance to providers participating in Medicaid to include this question,

   - Providing reimbursement to providers for asking these questions, and

   - Ensuring that coding supports such reimbursement.

State Examples:

- Michigan: In 2007, a statewide advisory group of providers in Michigan built a new evidence-based Clinical Guideline, approved through the Michigan Quality Improvement Consortium, and a toolkit for physicians and other providers to use in counseling their patients. Health care providers were supported with user-friendly resources and challenged to engage their patients (men and women of childbearing age) in conversation about family planning, to ask them about their intentions regarding pregnancy and to provide information on family planning. The guidelines were updated in July 2016.

Resources:

- Michigan Quality Improvement Consortium Guideline Prevention of Unintended Pregnancy in Adults 18 Years and Older: http://www.mqic.org/pdf/mqic_prevention_of_unintended_pregnancy_in_adults_18_years_and_older_cpg.pdf

- Preventing Unintended Pregnancy in Adults Provider Toolkit (Michigan): http://www.mqic.org/pdf/Preventing_Unintended_Pregnancy_in_Adults_207766_7_Toolkit.pdf

- Reproductive Life Plan Tool for Health Professionals: https://www.cdc.gov/preconception/rlptool.html

- Contraception as a Quality Metric: http://www.pcpci.org/sites/default/files/webinar-related/Contraception%20as%20a%20Quality%20Metric_Webinar%20Slides_FINAL.pdf

23. Contraception counseling provided by clinic staff (clinician or non-clinician) is reimbursable.

    Clinic administrators should also consider how to best implement and be reimbursed for procedures in their clinic that allow clients to participate in evidence-based contraceptive counseling for patients who are not seeking pregnancy. This might mean involving other trained staff in the counseling process. However, current billing practices generally do not usually allow reimbursement for contraceptive counseling provided by a non-clinician.

Resources:

- Barriers and facilitators to implementing a patient-centered model of contraceptive provision in community health centers: https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0032-3

- Long-Acting Reversible Contraception: State-Level and Regional Research on Reducing Barriers to Access: http://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARCState_Research.pdf

- Intrauterine Devices & Implants: A Guide To Reimbursement: http://larcprogram.ucsf.edu/coding

24. Family-planning services can be provided by and reimbursed for any willing and qualified provider including pharmacists.

    As noted above, in recent years, in an effort to provide more access to contraceptive methods, some states have passed legislation allowing pharmacists to provide some methods of birth control.

State Examples:

As states consider this policy option, there are number of factors to consider, including the issue of reimbursement for the counseling provided by pharmacists. Hawaii's legislation explicitly enables pharmacists to be reimbursed. In Oregon, there is a one-time fee that ranges from $35-45, which customers must currently pay for out of pocket. Other states considering this policy should bear in mind whether insurance covers the counseling fees and the financial burden that out of pocket costs may add to customers.

- Hawaii: http://capitol.hawaii.gov/measure_indiv.aspx?billtype=SB&billnumber=513&year=2017

- Washington: http://app.leg.wa.gov/billsummary?BillNumber=2681&Year=2015#documents

- State Board of Pharmacy in California: http://www.pharmacy.ca.gov/laws_regs/1746_1_pt.pdf

Resources:

- State Policies to Increase Information About and Access to Contraception: https://powertodecide.org/what-we-do/information/resource-library/briefly-state-policies

Other

25. Private insurance plans include a confidentiality policy for dependents and spouses.

    Confidentiality is a concern with respect to receipt of health care in general and specifically with respect to reproductive health care services. In particular, through private insurance, the provision of an Explanation of Benefits (EOB) to policyholders can include such information as: the individual who received care, provider type, and a description of the care received. To overcome these confidentiality challenges, as of May 2017, 13 states have adopted provisions aimed at protecting confidentiality. About half of these policies are specific to minors, which is important, but not inclusive of a dependent who is not a minor, but may want to make private decisions in particular about contraceptive method use.

Resources:

- Protecting Confidentiality for Individuals Insured as Dependents: https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents.

- Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X: https://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf

Education and Communication

Given the low familiarity among adults regarding the full range of contraceptive methods, education and communication is a critical component to an initiative seeking to improve supply of and demand for contraception. It is also the case that some specific methods will require a clinical visit, in which case consumers must have information about where they can access care.

For the purposes of this framework, education refers to formal or informal sexual health education that specifically includes information about the full-range of contraceptive methods. Communications refers to a specific media campaign (i.e. advertisements) focused on a specific goal (i.e. increased awareness of birth control options, increased awareness of the BBC Initiative) delivered via various channels—digital or more traditional channels (i.e. print media).

It may be the case that in a particular community or region these efforts are connected in some way, but more likely they are separate. For work on increasing awareness of and demand for the full range of contraceptive methods, we recommend that there is a specific focus on contraception within education and communication efforts. It is also the case that education and communication about sexual health may be much broader than contraception and may include topics such as healthy relationships, partner negotiation and communication, sexually transmitted infections, and consent, among others. The following best practices consider education and communication activities with a particular focus on increasing demand for contraception.

1. There is an assessment of existing sexual health education efforts.

    Before developing or implementing a sexual health education program, you should determine if contraception education programs exist in your community.

    To find out about sexual health education programming, check with public schools, colleges, the public health department, child welfare agencies, clinics, and community-based organizations to find out what, if any, curricula are being used, or what information is provided to adolescents on topics related to sexual and reproductive health. If relevant, there may be a teen pregnancy prevention or adolescent health coalition/organization that can provide you with information about these programs.

Resources:

*   Best Practices for Conducting a Needs and Resource Assessment: Tip Sheet: https://www.hhs.gov/ash/oah/sites/default/files/needs-assessment-508.pdf

*   WISE Toolkit: http://www.wisetoolkit.org/toolkit/scan-current-efforts-and-policies

*   Getting To Outcomes: http://www.healthyteennetwork.org/resources/gto-toolbox/

2. There is a mechanism/strategy for ongoing assessment of communication campaigns and social norms related to family formation, pregnancy, and contraception.

    Before you develop a communications campaign, you'll want to find out what campaigns have been done in the past for your target audience. Determine if there have been any successful campaigns on a topic related to birth control or sexual health that have evaluation data and can potentially serve as a model.

    In conjunction with identifying existing or previous communication efforts, you want to assess the target audiences' knowledge, attitudes, and norms on family formation, pregnancy, and contraception. You will want to know how they currently access birth control and information. This can be done through

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focus groups, surveys, and/or key informant interviews. Once the assessment is developed, it can be used throughout the BBC Initiative to measure changes and progress towards established goals. Online surveys, including those conducted through Facebook or SurveyMonkey, are a low-cost way to assess community attitudes and knowledge. Also, determine if a local university or other entity conducts any polling data with adults in the community and if the initiative could add any questions. Determine if there are other surveys such as the Behavioral Risk Factor Surveillance Survey or the Youth Risk Behavior Survey conducted in your state/community.

For example, in Charlotte, NC, 10 questions related to the community's attitudes about unplanned pregnancy and prevention efforts were added to the Charlotte-Mecklenburg Annual Survey. The annual phone survey was conducted by UNC Charlotte's Urban Institute and the data provided valuable information about community support for policies and programs related to unplanned pregnancy prevention. This survey is conducted annually and there is an opportunity, each year, to include these survey questions for a small fee.

Resources:

- Collecting Qualitative Data on Youth Perceptions Regarding Teen Pregnancy and HIV Prevention: A Focus Group Guide: http://www.massteenpregnancy.org/sites/default/files/providers/etr-focus-group-guide.pdf

- Sample Focus Group Discussion And In-Depth Interview Guides: Community Awareness of and Barriers to Longer-Acting and Permanent Contraception: https://www.k4health.org/sites/default/files/Tools_fgdguide.pdf

- Making Health Communication Programs Work: https://www.cancer.gov/publications/health-communication/pink-book.pdf

- Talking the Talk: Creating a Communications Strategy: https://powertodecide.org/what-we-do/information/resource-library/talking-the-talk

3. All youth have access to medically-accurate, and age-appropriate sexual health education, including information on the full range of birth control methods.

Youth need access to sexual health education that is accurate, appropriate, and includes information about the full range of birth control methods. Sexual health education can be provided in a variety of mediums: in-person at school (including colleges) or a community-based organization; online through trusted resources; and via mobile devices. It may be a formal part of a curriculum or something that individuals seek on their own (i.e. website). The assessment that you've conducted of services available in the community will highlight where there are gaps in ensuring that information is widespread and ubiquitous for youth in your community. It may involve increasing awareness of particular informational websites, working to integrate sexual health education into existing systems, or working with parents and other health care providers to increase access to information for young people.

Resources

- Sexuality Education for Children and Adolescents: http://pediatrics.aappublications.org/content/pediatrics/early/2016/07/14/peds.2016-1348.full.pdf

- Community Spotlight: CASE STUDIES Implementing a New Sexual Health Education Law in North Carolina: https://powertodecide.org/what-we-do/information/resource-library/community-spotlight-case-studies-implementing-new-sexual

- Office of Adolescent Health TPP Resource Center: Evidence-Based Programs: https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/evidence-based-programs/index.html

- Working to Institutionalize Sex Education: http://www.wisetoolkit.org/

- Future of Sex Ed: National Sex Education Standards and National Teacher Preparation Standards: http://www.futureofsexed.org/

- Centers for Disease Control and Prevention. Increasing Access to Sexual Health Services: http://www.cdc.gov/healthyyouth/sexualhealth/pdf/sexualhealth-factsheet.pdf

- Centers for Disease Control and Prevention. Adolescent and School Health: Program Tools: http://www.cdc.gov/healthyyouth/tools/index.htm

- Strategies for LARC Patient Outreach: http://www.astho.org/Maternal-and-Child-Health/LARC-and-Patient-Outreach-Fact-Sheet/

- Arkansas Focuses on College Students to Lower Teen Pregnancy and Birth Rates: http://astho.org/Maternal-and-Child-Health/Arkansas-Focuses-on-College-Students-to-Lower-Teen-Pregnancy-and-Birth-Rate/

- State Policies to Educate College Students about Unplanned Pregnancy: https://powertodecide.org/what-we-do/information/resource-library/state-policies-to-educate-college-students

4. All formal, in-person sexual health education is science-based, medically accurate, and culturally- and age-appropriate.

   Sexual health education needs to be provided by a skilled and trained individual who is comfortable with the topic area, aware of current and relevant resources, understand cultural and community norms, and able to provide referrals to adolescent-friendly health services. Schools, child welfare agencies, health clinics, and community-based organizations are just some of the organizations who may provide this education.

   If you find that these organizations are already using a curriculum but you are unsure of how it meets specific criteria, tools such as the HECAT and the National Sexuality Education Standards, can assist. If no curriculum exists and one needs assistance with selecting one, tools such as Getting to Outcomes can lead you through a process to select the best option for your community. Keep in mind particular cultural values as you identify curricula options. You can also use the list of evidence-based teen pregnancy prevention programs developed by the Department of Health and Human Services. This list includes over 40 programs that have been evaluated and proven successful.

Resources

- Office of Adolescent Health TPP Resource Center: Evidence-Based Programs: https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/evidence-based-programs/index.html

- Working to Institutionalize Sex Education: http://www.wisetoolkit.org/

- Future of Sex Ed: National Sex Education Standards and National Teacher Preparation Standards: http://www.futureofsexed.org/

- Centers for Disease Control and Prevention. Increasing Access to Sexual Health Services: http://www.cdc.gov/healthyyouth/sexualhealth/pdf/sexualhealth-factsheet.pdf

- Centers for Disease Control and Prevention. Adolescent and School Health: Program Tools: http://www.cdc.gov/healthyyouth/tools/index.htm

5. There are ongoing communication efforts, based on best practices, to increase awareness of the initiative and/or contraception.

   Widespread communication efforts might be the best way to share information about the initiative or the issue in your community. Specific best practices for implementing a high quality and effective communication campaign include:

   - Define a target audience. Examples include females age 18-24, youth age 10-14, etc.

   - Use the results of a needs assessment (see BP#1) to identify gaps and areas for improvement.

   - Engage marketing and communication professionals with expertise in the identified target audience in the development of the communications campaign.

   - Engage the end-user/consumer as co-designers in communication efforts.

   - Use language that resonates with the community.

       - Use a health equity framework in your communications plans:

           ◦ This includes working with the intended audience to determine what is culturally relevant in terms of language and channels of communication used. This also means identifying cultural norms and adjusting messages based on such norms.

           ◦ Consider those who may be left out, or have difficulty accessing information such as people with limited access to the internet, people with disabilities, and the LGBTQIA community.

       - Understand the history of coercion related to reproductive health and its application to your work.

   - Understand and use a reproductive justice framework to craft messages.

   - Develop the campaign using the latest research on adolescent development and brain science.

   - Have a clear call to action.

The communications campaign needs to be regularly monitored to measure progress and inform real-time adjustments. Specifically, monitor both implementation analytics of the campaign as well as behavioral outcomes (when possible).

- Implementation analytics include:

    - Engagement (e.g. number of clicks, downloads, views, time on site).

    - Audience demographics (to ensure you are reaching the right audience).

- Identify behavioral outcomes to monitor, as appropriate, for each target audience.

    - Key metrics should be related to the relevant call to action and may include:

        ◦ Awareness of the campaign.

        ◦ Knowledge levels/changes over time.

        ◦ Sentiment/attitudes.

As communication efforts are developed and executed, special attention should be paid to digital efforts.

Resources:

- Making Health Communication Programs Work: https://www.cancer.gov/publications/health-communication/pink-book.pdf

- Talking the Talk: Creating a Communications Strategy: https://powertodecide.org/what-we-do/information/resource-library/talking-the-talk

- Gateway to Health Communications and Social Marketing Practices (a variety of resources including health literacy and evaluation resources): https://www.cdc.gov/healthcommunication/

- CRRJ Reproductive Justice Virtual Library: https://www.law.berkeley.edu/research/center-on-reproductive-rights-and-justice/crrj-reproductive-justice-virtual-library/

- Office of Adolescent Health, Strategic Communications Toolkit: https://www.hhs.gov/ash/oah/resources-and-publications/learning/sc-tk/index.html

- Community Spotlight: Strategies For Communications Campaigns: https://powertodecide.org/what-we-do/information/resource-library/community-spotlight-case-studies-strategies-for

- Strategies for LARC Patient Outreach: http://www.astho.org/Maternal-and-Child-Health/LARC-and-Patient-Outreach-Fact-Sheet/

- Whoops Proof: https://powertodecide.org/what-we-do/information/resource-library/whoops-proof-birth-control and https://powertodecide.org/what-we-do/information/resource-library/whoops-proof-birth-control-insights

6. There is a digital presence for the community BBC initiative.

    A digital presence is important, especially when conducting communication efforts. The digital presence may include a website and social media channels for the BBC Initiative more broadly, as well as coordinated but separate sites and channels for more outreach to specific populations. It is increasingly possible to use existing digital tools that require little or no expertise in website or digital tools creation. For example, tools such as Basecamp can be used to organize content and contributors, Jive can be used for organizing communities, and Medium can be used for publishing.

Resources

- Using Social Media to Engage Participants: http://www.michigan.gov/documents/mdch/Using_Social_Media_to_Engage_Participants_Tip_Sheet_FINAL_4-18-14_456292_7.pdf

- The Health Communicator's Social Media Toolkit: https://www.cdc.gov/healthcommunication/ToolsTemplates/SocialMediaToolkit_BM.pdf

- 6 Steps to Evaluate and Optimize Your Organization's Use of Digital Tools: http://vtrural.org/sites/default/files/content/DigitalEconomy/Evaluating-Your-Organizational-Use-Of-Digital-Tools.pdf

Health Equity and Cultural Humility

Given the history of injustice surrounding reproductive health and the provision of contraceptive devices and services for women of color and low-income women, it is critical that initiatives interested in increasing use of the full range of contraceptive methods consider best practices related to health equity and cultural humility. The historical abuses of the past cannot be used as pretense for not engaging the communities most in need of accurate, relevant, and resonant information if real, sustainable, community-wide change is to occur. For the purposes of this framework, the best practices covered below are rooted in meeting communities where they are, providing them with culturally and linguistically relevant and appropriate information and services, and ensuring they have equitable access to information, services, and resources that may be obtained as a result of the successful implementation of the framework.

Successfully addressing the needs of all women in a given community requires identifying who is in your community. Using Census data as well as reaching out to local community based organizations will help determine, at the outset of this work, which women are most in need of information and services. Additionally, before the BBC Blueprint for Action is created, it is important to directly engage women of color and low-income women and the organizations that represent and serve them to ensure that their voices are heard and their needs are met.

This domain is a critical component of the framework and the activities that will be undertaken. While it is interwoven into each of the domains, the list below can function as a checklist to ensure that no Health Equity and Cultural Humility-related best practices are overlooked.

Best Practice	Domain	Guidance Page Number
There is a state/regional committee in place that is representative of the community demographics and culture that meets at least four times per year to discuss activities and progress (Step 1 in QI process).	Getting Started and Keeping it Going	page 15
Key BBC outcomes identified in the Blueprint for Action are: • collected and disaggregated by race, ethnicity, and socioeconomic status, • tracked annually (existing data sources should be used first); and • shared publicly at least bi-annually.	Getting Started and Keeping it Going	page 19

Best Practice	Domain	Guidance Page Number
There is a clear plan for collecting and reporting on consumer feedback—including youth and young adults— on the BBC initiative.	Getting Started and Keeping it Going	page 22
Create an inclusive environment and ensure that services are inclusive of, appropriate for, and responsive to the needs of racial and ethnic minorities, teens, men, LGBTQIA persons, and persons with disabilities.	Health Care Delivery System	page 25
The majority of public clinics provide person-centered, autonomous care to all clients.	Health Care Delivery System	page 28
The majority of public clinics use a team-based health care delivery approach.	Health Care Delivery System	page 34
The majority of public clinics follow National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.[13]	Health Care Delivery System	page 36
The majority of public clinics use best practices for health literacy including transcreation of materials for different cultures.	Health Care Delivery System	page 38
The majority of public clinics offer training topics annually for all providers and staff not previously trained in topics critical to effective delivery of high quality contraceptive care or as new guidelines are released.	Health Care Delivery System	page 40

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13   Fifteen standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

Best Practice	Domain	Guidance Page Number
The majority of public clinics offer additional training or resources on other topics including: • Working with diverse communities within their region and understanding their specific community dynamics; • Importance of contraceptive initiative/ contraception access; • Adolescent development (including cognitive/ neurological development); • Behavior-change theory; • Trauma-informed care; • Communication skills, specifically how to communicate with patients.	Health Care Delivery System	page 43
State has received approval, through an SPA, to implement Medicaid/Children's Health Insurance Program (CHIP) coverage of lawfully residing immigrant children and pregnant women without a five-year waiting period.	Policy	page 53
There are ongoing communication efforts, based on best practices, to increase awareness of the initiative and/ or contraception.	Communications and Education	page 65

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